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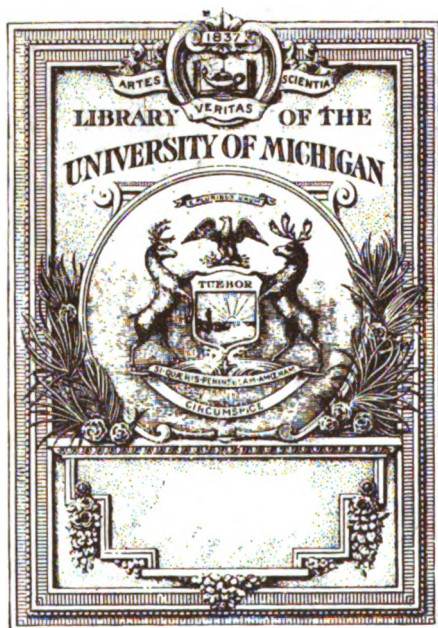
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*J. H. Anglin*

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

PROCEEDINGS

HELD AT

CHICAGO, ILLINOIS



PUBLISHED BY  
AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION  
1918



*J. H. Anglin*



# PROCEEDINGS

OF THE

*Psychiatric*  
~~American Medico-Psychological Association~~

AT THE

SEVENTY-FOURTH ANNUAL MEETING

HELD AT

CHICAGO, ILL., June 4-7, 1918



PUBLISHED BY

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1918



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## TABLE OF CONTENTS

---

List of Members.....	9
Life Members .....	47
Honorary Members.....	48
Necrology .....	49
Presidents of the Association.....	50
Secretaries of the Association.....	51
Meeting Places of the Association.....	52
Geographical Distribution of Members and Institutions.....	53
Constitution .....	86
By-Laws .....	91
Note .....	92
Proceedings of the Seventy-fourth Annual Meeting.....	93
Presidential Address. JAMES V. ANGLIN.....	139
The Psychologic Treatment of Retarded Depressions. L. PIERCE CLARK.....	157
The Content of the Schizophrenic Characteristics Occurring in Affective Disorders. PHYLLIS GREENACRE.....	161
A Critical Review of the Pathogenesis of Dementia Praecox, with a Discussion of the Relation of Psychoanalytic Principles. MICHAEL OSNATO .....	167
Interpretation of the Functional Nervous Diseases at the Physico-chemical Level. D. W. ROBERTS.....	189
The Mental Deficiency Survey of Kentucky, 1917. THOMAS H. HAINES.....	195
The Organization of the State Hospital Service in Illinois. H. DOUGLAS SINGER .....	207
The Rehabilitation in the Community of Patients Paroled from Institutions for the Insane. SAMUEL N. CLARK.....	217
A Clinical Summary of 106 Cases of Mental Disorder of Unknown Etiology Arising in the Fifth and Sixth Decades. E. T. GIBSON... ..	223
Recent American Classifications of Mental Diseases. E. E. SOUTHARD.....	253
The Study of Personality in Psychiatric Cases. GEORGE S. AMSDEN....	273
Treatment in Neurosyphilis. BENJAMIN F. WILLIAMS.....	285
Pellagra at the Connecticut Hospital for the Insane. WILLIAM C. SANDY .....	289
The Work of Psychiatrists in Military Camps. E. STANLEY ABBOT....	299
Food, Service and Conservation in a Provincial Hospital. J. C. MITCHELL .....	309
Psychoses in Mental Defects. ALFRED GORDON.....	317
The Nursing Problem as Related to Psychopathology. RICHARD DEWEY.....	329
The Community Mental Health Movement and its Probable Dependence for Success on a Higher State Hospital Standard for Ward Employees. SIDNEY D. WILGUS.....	337

An Analysis of the Accuracy of Psychopathic Hospital Diagnoses.	
LAWSON GENTRY LOWREY.....	349
Memorial Notices:	
John B. Chapin, M. D., LL. D. EDWARD N. BRUSH.....	369
Dr. Charles H. North.....	386
Dr. George Villeneuve .....	389
Dr. Thomas Coke Biddle. M. L. PERRY.....	391
Subject Index .....	393
Authors' Index .....	396



**LIST OF MEMBERS**  
**—OF THE—**  
**AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION**  
**May, 1919**

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(This list printed on gummed paper, for mailing purposes, may be obtained from the Secretary. Price 50c.)

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**A**

- 1895 **Abbot, E. Stanley, M. D.**, 592 Pleasant St., Waverley, Mass.
- 1907 **Abbot, Florence Hale, M. D.**, Assistant Physician Boston State Hospital, Dorchester Center, Mass.
- 1917 **Adams, Felix M., M. D.**, Superintendent East Oklahoma Hospital, Vinita, Okla.
- 1904 **Adams, Geo. Sheldon, M. D.**, Assistant Superintendent South Dakota Hospital for the Insane, Yankton, S. D.
- 1914 **Adler, Herman M., M. D.**, 1812 West Polk St., Chicago, Ill.
- 1917 **Alford, DeLand B., M. D.**, Pathologist Boston State Hospital, Dorchester Centre, Mass. (*Associate.*)
- 1903 **Allen, Charles Lewis, M. D.**, Los Angeles, Cal.
- 1912 **Allen, Frederick E., M. D.**, Physician-in-Charge Elmwoods Sanitarium, Llewellyn Road, Hayward, Cal.
- 1893 **Allen, Henry D., M. D.**, Superintendent Invalids Home, Milledgeville, Ga.
- 1913 **Allen, J. Berton, M. D.**, Assistant Physician Central Islip State Hospital, Central Islip, N. Y.
- 1912 **Allison, W. L., M. D.**, Superintendent Arlington Heights Sanitarium, Fort Worth, Tex.
- 1913 **Alsbaugh, Paul J., M. D.**, First Assistant Physician Massillon State Hospital, Massillon, O.
- 1913 **Amsden, George S., M. D.**, Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)
- 1915 **Anderson, Albert, M. D.**, Superintendent State Hospital, Raleigh, N. C.
- 1915 **Anderson, Paul V., M. D.**, Resident Physician Westbrook Sanatorium, Richmond, Va.
- 1916 **Anderson, Victor V., M. D.**, National Committee Mental Hygiene, 50 Union Square, New York, N. Y. (*Associate.*)
- 1894 **Anglin, James V., M. D.**, Medical Superintendent The Provincial Hospital, St. John, New Brunswick. (*President, 1918.*)

- 1895 Applegate, Charles F., M. D., Medical Superintendent Mt. Pleasant State Hospital, Mt. Pleasant, Ia.  
 1918 Arkebauer, C., M. D., Senior Assistant Physician State Hospital for Nervous Diseases, Little Rock, Ark. (*Associate.*)  
 1903 Armstrong, George G., M. D., Senior Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)  
 1913 Armstrong, Samuel T., M. D., Physician-in-Charge Hillbourne Club, Katonah, N. Y.  
 1904 Ashley, Maurice C., M. D., Medical Superintendent Middletown State Homeopathic Hospital, Middletown, N. Y.  
 1890 Atwood, Charles E., M. D., 14 E. 60th St., New York, N. Y.

## B .

- 1911 Baber, Armitage, M. D., Superintendent Dayton State Hospital, Dayton, O.  
 1915 Bachelder, Frank S., M. D., Assistant Superintendent Pontiac State Hospital, Pontiac, Mich. (*Associate.*)  
 1913 Baker, Amos T., M. D., U. S. Disciplinary Barracks, Governors Island, New York, N. Y.  
 1904 Baker, Benjamin W., M. D., Superintendent New Hampshire School for Feeble-Minded Children, Laconia, N. H.  
 1909 Baldwin, Louis B., M. D., Superintendent University Hospital, University of Minnesota, Minneapolis, Minn.  
 1917 Ball, Charles R., M. D., 1044 Lowry Bldg., St. Paul, Minn.  
 1916 Ball, Jau Don, M. D., Oakland, Cal.  
 1898 Ballintine, Eveline P., M. D., Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)  
 1918 Ballou, Harry B., M. D., Senior Assistant Physician Westborough State Hospital, Westborough, Mass. (*Associate.*)  
 1896 Bamford, Thos. E., M. D., 418 Delaware St., Syracuse, N. Y.  
 1883 Bancroft, Chas. P., M. D., Concord, N. H. (*President, 1908.*)  
 1890 Bannister, Henry M., M. D. (formerly Assistant Physician Illinois Eastern Hospital for the Insane), 828 Judson Ave., Evanston, Ill. (*Honorary.*)  
 1915 Bannon, Freeman R., M. D., Bloomingdale, Ind. (*Associate.*)  
 1912 Barber, Bruce B., M. D., Ashley, O. (*Associate.*)  
 1913 Barlow, Charles A., M. D., U. S. G. H. 26, Ft. Des Moines, Iowa.  
 1912 Barnes, E. C., M. D., Assistant Physician Homewood Sanitarium, Guelph, Ont. (*Associate.*)  
 1909 Barnes, Francis M., Jr., M. D., 910 University Club Building, St. Louis, Mo.  
 1914 Barnhardt, Wm. N., M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)

- 1898 Barrett, Albert M., M.D., Professor of Psychiatry and Neurology University Hospital, Ann Arbor, Mich.
- 1916 Barrett, Thos. M., M.D., Emsworth, Pa. (*Associate.*)
- 1914 Barry, R. Grant, M.D., Assistant Physician New Jersey State Hospital, Trenton, N. J.
- 1912 Bartram, Nell W., M.D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1914 Baskett, George T., M.D., Assistant Superintendent St. Peter State Hospital, St. Peter, Minn.
- 1913 Bass, T. B., M.D., Superintendent Texas State Epileptic Colony, Abilene, Tex.
- 1900 Becker, W. F., M.D., Consulting Neurologist Milwaukee County Hospital, 604 Goldsmith Building, Milwaukee, Wis.
- 1892 Beemer, Nelson H., M.D., Superintendent Mimico Hospital for the Insane, Toronto, Ont.
- 1902 Beling, Christopher C., M.D. (formerly Assistant Physician New Jersey State Hospital, Morris Plains, N. J.), 109 Clinton Ave., Newark, N. J.
- 1913 Bellinger, Clarence H., M.D., Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)
- 1915 Bentley, Inez A., M.D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1893 Berkley, Henry J., M.D., 1305 Park Ave., Baltimore, Md.
- 1904 Betts, Joseph B., M.D., Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)
- 1899 Beutler, W. F., M.D., Medical Superintendent Milwaukee Asylum for the Chronic Insane, Wauwatosa, Wis.
- 1913 Blaisdell, Russell E., M.D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1914 Blauvelt, John H., M.D., 92 Liberty St., New York, N. Y. (*Associate.*)
- 1917 Bledsoe, Edwin P., M.D., Little Rock, Ark.
- 1916 Bliss, Geo. S., M.D., Superintendent School for Feeble-Minded Youth, Ft. Wayne, Ind.
- 1912 Bloss, James R., M.D., P. O. Box 453, Huntington, W. Va. (*Associate.*)
- 1886 Blumer, G. Alder, M.D., Medical Superintendent Butler Hospital, Providence, R. I. (*President, 1903.*)
- 1918 Bolton, H. A., M.D., Assistant Superintendent Montana State Hospital, Warm Springs, Montana. (*Associate.*)
- 1909 Bond, Earl D., M.D., Senior Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.
- 1907 Bond, George F. M., M.D., Proprietor Dr. Bond's House, 960 N. Broadway, Yonkers, N. Y.
- 1892 Bondurant, Eugene D., M.D. (formerly Assistant Superintendent Alabama Bryce Hospital), 166 Conti St., Mobile, Ala.

- 1918 Bonner, Clarence A., M. D., Assistant Physician Warren State Hospital for the Insane, Warren, Pa. (*Associate.*)
- 1913 Borden, P. G., M. D., Capt. M. C. U. S. A. G. H. 40, St. Louis, Mo. (*Associate.*)
- 1917 Bowman, Carl Murdock, M. D., Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)
- 1912 Boyd, Wm. A., M. D., Schofield Barracks, Hawaii.
- 1904 Bradley, Isabel A., M. D., Assistant Physician Columbus State Hospital, Columbus, O.
- 1914 Braunlin, Edgar L., M. D., 536 Ludlow St. Arcade, Dayton, O.
- 1916 Brewster, David T., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1910 Brewster, George F., M. D., 264 W. 57th St., New York, N. Y.
- 1907 Briggs, L. Vernon, M. D., 64 Beacon St., Boston, Mass.
- 1913 Brill, A. A., M. D., 1 W. 70th St., New York, N. Y.
- 1906 Brochu, M. D., M. D., Superintendent Beauport Asylum for Insane, Beauport, Que.
- 1915 Brodsky, Emanuel S., M. D., Assistant Superintendent Westport Sanatorium, Westport, Conn.
- 1910 Brooks, Swepeon J., M. D., Physician-in-Charge St. Vincent's Retreat, Harrison, N. Y.
- 1918 Brophy, J. W., M. D., Assistant Physician Montana State Hospital, Warm Springs, Montana. (*Associate.*)
- 1914 Brothers, J. E., M. D., Assistant Physician State Hospital, Goldsboro, N. C. (*Associate.*)
- 1913 Brown, G. W., M. D., Superintendent Eastern State Hospital, Williamsburg, Va.
- 1917 Brown, J. F. Leigh, M. D., Assistant Physician Verdun Hospital, Verdun, Que.
- 1914 Brown, Louis R., M. D., Assistant Physician Hospital for Insane, Middletown, Conn. (*Associate.*)
- 1883 Brown, Sanger, M. D., Physician-in-Chief Kenilworth Sanitarium, Kenilworth, Ill.
- 1913 Brown, Sanger, II, M. D., Lt. Col. M. C. Debarkation Hospital 51, National Soldiers Home, Va. (*Associate.*)
- 1912 Brown, Sherman, M. D., Superintendent Kenilworth Sanitarium, Kenilworth, Ill. (*Associate.*)
- 1899 Brown, W. Stuart, M. D., Physician-in-Charge Sanford Hall, Flushing, New York, N. Y.
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- 1912 Brundage, Howard M., M. D., 112 E. Broad St., Columbus, O.
- 1908 Brunk, Oliver C., M. D., 405 E. Grace St., Richmond, Va.
- 1891 Brush, Edward N., M. D., Physician-in-Chief and Superintendent Sheppard and Enoch Pratt Hospital, Towson, Md. (*President, 1916.*)
- 1918 Brush, Nathaniel H., M. D., Assistant Resident Physician Phipps Psychiatric Clinic, Baltimore, Md. (*Associate.*)

- 1912 Bryan, Wm. A., M. D., Assistant Physician Cherokee State Hospital, Cherokee, Ia. (*Associate.*)
- 1895 Bryant, Percy, M. D. (formerly Medical Superintendent Male Department Manhattan (N. Y.) State Hospital), Bowdoin Park, Rahway, N. J.
- 1891 Buchanan, J. M., M. D., Meridian, Miss.
- 1912 Buckley, Albert C., M. D., Superintendent Friends' Hospital, Frankford, Philadelphia, Pa. (*Associate.*)
- 1898 Buckley, James M., D. D., LL. D., Morristown, N. J. (*Honorary.*)
- 1915 Buell, Blinn A., M. D., Guilford, N. Y. (*Associate.*)
- 1902 Bullard, E. L., M. D. (formerly Superintendent Wisconsin State Hospital for the Insane, Mendota, Wis.), Proprietor and Physician-in-Charge Chestnut Lodge Sanitarium, Rockville, Md.
- 1905 Burdick, Charles M., M. D., Senior Assistant Physician Central Islip State Hospital, Central Islip, L. I., N. Y. (*Associate.*)
- 1913 Burdick, Elijah S., M. D., Assistant Physician Southern California State Hospital, Patton, Cal. (*Associate.*)
- 1890 Burgess, T. J. W., M. D., Medical Superintendent Protestant Hospital for the Insane, New P. O. Box 2280, Special Bag, Montreal, Que. (*President, 1905.*)
- 1909 Burlingame, C. C., M. D., South Manchester, Conn. (*Associate.*)
- 1894 Burnet, Anne, M. D., 303 Superior St., Antigo, Wis.
- 1913 Burnett, S. Grover, M. D., Medical Superintendent The Burnett Sanitarium, 3100 Euclid Ave., Kansas City, Mo.
- 1914 Burns, Geoffrey C. H., M. D., Senior Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
- 1890 Burr, C. B., M. D., Medical Director Oak Grove Hospital, Flint, Mich. (*President, 1906.*)
- 1907 Burr, Chas. W., M. D., Professor of Mental Diseases University of Pennsylvania, 1918 Spruce St., Philadelphia, Pa.
- 1917 Burrier, Walter, M. D., Assistant Physician State Hospital, Medfield, Mass. (*Associate.*)
- 1901 Busey, A. P., M. D., Superintendent Colorado State Home and Training School for Mental Defectives, Ridge, Colo.
- 1917 Butler, Robert Morris, M. D., Jackson, Miss.
- 1910 Butterfield, George K., M. D., Grafton State Hospital, Worcester, Mass. (*Associate.*)

## C

- 1902 Calder, Daniel H., M. D., Pasadena, Cal.
- 1917 Campbell, Charles Macfie, M. D., Associate in Psychiatry Johns Hopkins Hospital, Baltimore, Md.
- 1907 Campbell, Earl H., M. D., Superintendent Upper Peninsula Hospital for the Insane, Newberry, Mich.
- 1899 Campbell, George B., M. D., First Assistant Physician Utica State Hospital, Utica, N. Y.

- 1885 Campbell, Michael, M. D., Knoxville, Tenn.
- 1914 Canavan, Myrtelle M., M. D., Assistant Pathologist Massachusetts Commission on Mental Diseases, Boston, Mass. (*Associate.*)
- 1901 Caples, Byron M., M. D., Medical Superintendent Waukesha Springs Sanitarium, Waukesha, Wis.
- 1909 Capron, Arthur J., M. D., Physician-in-Charge Glenmary Sanitarium, Owego, N. Y.
- 1914 Carey, Charles J., M. D., Superintendent Eastern Shore State Hospital, Cambridge, Md.
- 1905 Carey, Harris May, M. D., 600 Pine St., Philadelphia, Pa.
- 1903 Carlisle, Chester Lee, M. D., Superintendent Division of Mental Defectives, State Board of Charities, Albany, N. Y.
- 1915 Carmichael, F. A., M. D., Superintendent Osawatomie State Hospital, Osawatomie, Kans.
- 1911 Carpenter, Howard P., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1906 Carriel, Henry B., M. D., Dixon State Colony, Dixon, Ill.
- 1911 Carroll, Robert S., M. D., Medical Director Highland Hospital, Asheville, N. C.
- 1913 Casamajor, Louis, M. D., 40 E. 41st St., New York, N. Y.
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- 1917 Cazenavette, Lionel L., M. D., 124 Baronne St., New Orleans, La.
- 1892 Chaddock, Chas. G., M. D., 3705 Delmar Boulevard, St. Louis, Mo.
- 1896 Chagnon, E. Philippe, M. D., 197 Esplanade Ave., Montreal, Que.
- 1880 Channing, Walter, M. D., Channing Sanitarium, Brookline, Mass.
- 1912 Chapman, Ross McC., M. D., First Assistant Physician St. Elizabeth Hospital, Washington, D. C.
- 1918 Charlton, G. E., M. D., Superintendent Norfolk Hospital for the Insane, Norfolk, Nebr.
- 1883 Chase, Robert H., M. D., Frankford, Philadelphia, Pa.
- 1914 Cheney, Clarence O., M. D., Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1912 Child, Howard T., M. D., Franklin, N. H. (*Associate.*)
- 1895 Chilgren, G. A., M. D., 413 Iowa State Bank Bldg., Burlington, Iowa.
- 1892 Christian, Edmund A., M. D., Medical Superintendent Pontiac State Hospital, Pontiac, Mich.
- 1916 Church, Mary Violet, M. D., Assistant Physician Massillon State Hospital, Massillon, O. (*Associate.*)
- 1918 Clare, Harvey, M. D., Assistant Superintendent Hospital for the Insane, Toronto, Canada.
- 1917 Clark, Carolyn, M. D., Assistant Physician Southwestern State Hospital, Marion, Va. (*Associate.*)
- 1907 Clark, Charles H., M. D., Superintendent Lima State Hospital, Lima, Ohio.
- 1910 Clark, Fred P., M. D., Superintendent State Hospital, Stockton, Cal.

- 1915 Clark, J. Henry, M. D., 12 Walnut St., Newark, N. J.
- 1898 Clark, Joseph Clement, M. D., Superintendent Springfield State Hospital, Sykesville, Md.
- 1906 Clark, L. Pierce, M. D., Consulting Neurologist Central Islip State Hospital, 128 E. 61st St., New York, N. Y.
- 1918 Clark, Samuel N., M. D., Assistant Physician Psychopathic Institute, Chicago, Ill. (*Associate.*)
- 1885 Clarke, Chas. K., M. D., Toronto, Ont.
- 1915 Clarke, H. G., M. D., Mayview, Bridgeville, R. D. 3, Pa. (*Associate.*)
- 1904 Clarke, Homer E., M. D., Assistant Medical Director, Oak Grove Hospital, Flint, Mich. (*Associate.*)
- 1917 Cleaves, Helen Taft, M. D., 450 Central Ave., Pacific Grove, Cal. (*Associate.*)
- 1915 Cline, Bernard McHugh, M. D., Assistant Physician Georgia State Sanitarium, Milledgeville, Ga. (*Associate.*)
- 1915 Cobb, O. H., M. D., Superintendent Syracuse State Hospital for Feeble-Minded Children, Syracuse, N. Y.
- 1898 Coe, Henry W., M. D., Medical Director Morning Side Hospital, 516 Selling Building, Portland, Ore.
- 1915 Coffin, Harriet F., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1905 Coggins, Jesse C., M. D., Medical Director The Laurel Sanitarium, Laurel, Md.
- 1913 Cohn, Eugen, M. D., M. O. Kankakee State Hospital, Kankakee, Ill.
- 1913 Cohoon, E. H., M. D., Superintendent Medfield State Hospital, Hard-  
ing, Mass.
- 1901 Coleburn, Arthur B., M. D., Capt. M. R. C., U. S. Army. (*Associate.*)
- 1909 Collier, G. Kirby, M. D., Assistant Physician Craig Colony for Epi-  
leptics, Sonyea, N. Y.
- 1912 Colnon, A. T., M. D., Assistant Physician St. Lawrence State Hos-  
pital, Ogdensburg, N. Y. (*Associate.*)
- 1915 Conlon, Wm. Alfred, M. D., Assistant Physician Central Islip State  
Hospital, Central Islip, N. Y. (*Associate.*)
- 1917 Conzelman, Fred, M. D., Clinical Director State Hospital, Stockton,  
Cal. (*Associate.*)
- 1894 Cook, R. Harvey, M. D., Physician-in-Chief Oxford Retreat, Oxford,  
Ohio.
- 1894 Cook, Robert G., M. D., Resident Physician Brigham Hall, Canandai-  
gua, N. Y.
- 1915 Cooper, A. S., M. D., Mansfield, La. (*Associate.*)
- 1892 Copp, Owen, M. D., Physician-in-Chief and Superintendent Penn-  
sylvania Hospital, Department for Nervous and Mental Diseases,  
West Philadelphia, Pa.
- 1912 Corcoran, David, M. D., Director Clinical Psychiatry Brooklyn State  
Hospital, Brooklyn, N. Y. (*Associate.*)
- 1903 Coriat, Isador H., M. D., 416 Marlborough St., Boston, Mass.

- 1908 Cornell, William B., M. D., State Board of Education, 51 Menand Road, Albany, N. Y.
- 1915 Cornwell, Herbert C. deV., M. D., Capt. M. R. C., U. S. Army.
- 1902 Cort, Paul Lange, M. D., 144 W. State St., Trenton, N. J. (*Associate.*)
- 1903 Cotton, Henry A., M. D., Medical Director New Jersey State Hospital, Trenton, N. J.
- 1914 Covey, Herman W., M. D., Assistant Physician St. Peter State Hospital, St. Peter, Minn. (*Associate.*)
- 1881 Cowles, Edward, M. D. (formerly Medical Superintendent McLean Hospital, Waverley), Plymouth, Mass. (*President, 1895.*)
- 1914 Cozad, H. Irving, M. D., Clinical Director Fair Oaks Villa, Cuyahoga Falls, O. (*Associate.*)
- 1912 Craig, Anna, M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1916 Craig, Joseph S., M. D., Assistant Physician Southeastern Hospital, Richmond, Ind. (*Associate.*)
- 1916 Crenshaw, Hansell, M. D., Atlanta, Ga.
- 1908 Crittenden, Samuel W., M. D., Soldiers Home Hospital, Chelsea, Mass. (*Associate.*)
- 1913 Crooks, Wm. A., M. D., Rock Island, Ill.
- 1892 Crumbacker, W. P., M. D., Medical Superintendent Independence State Hospital, Independence, Ia.
- 1917 Cuddy, Thomas, M. D., Assistant Physician Channing Sanitarium, Wellesley, Mass. (*Associate.*)
- 1913 Curry, Marcus A., M. D., Senior Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)
- 1913 Curtis, Barbara, M. D., Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)

## D

- 1914 Darling, Ira A., M. D., Assistant Physician State Hospital, Warren, Pa. (*Associate.*)
- 1899 Darling, W. H., M. D., Masonic Temple, Minneapolis, Minn. (*Associate.*)
- 1902 Darnall, Rolland F., M. D., Clinical Director and Assistant Superintendent State Hospital for Nervous Diseases, Little Rock, Ark.
- 1915 Darrow, Fred L., M. D., Assistant Physician Eastern Indiana Hospital, Richmond, Ind. (*Associate.*)
- 1916 Davidson, A. J., M. D., Assistant Physician Central State Hospital, Lakeland, Ky. (*Associate.*)
- 1913 Davies, George W., M. D., Essex County Hospital for Insane, Cedar Grove, N. J. (*Associate.*)
- 1918 Day, Homer L., M. D., Interne Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1909 De Jarnette, J. S., M. D., Medical Superintendent Western State Hospital, Staunton, Va.



- 1913 DeLaHoyde, T. Grover, M. D., Assistant Physician Norwalk State Hospital, Norwalk, Cal. (*Associate.*)
- 1916 DeLand, Maude S., M. D., Assistant Physician Topeka State Hospital, Topeka, Kans. (*Associate.*)
- 1917 DeMahy, Marcel J., M. D., Neurologist Town Infirmary, New Orleans, La.
- 1909 Dennea, Blanche, M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1915 Deuschle, W. D., M. D., 112 E. Broad St., Columbus, Ohio.
- 1915 Devendorf, Frederick C., M. D., 376 Genessee St., Utica, N. Y. (*Associate.*)
- 1912 Devlin, Francis E., M. D., Superintendent Hospital St. Jean de Dieu, Gamelin, Que. (*Associate.*)
- 1911 De Weese, Cornelius, M. D., Medical Director The Laurel Sanitarium, Laurel, Md.
- 1890 Dewey, Chas. G., M. D., Examining Physician Registration Department City of Boston, 44 Alban St., Dorchester, Boston, Mass.
- 1881 Dewey, Richard, M. D., Physician-in-Charge Milwaukee Sanitarium, Wauwatosa, Wis. (*President, 1896.*) Chicago office, 34 Washington St., Marshall Field Annex Bldg., Wednesdays, 11.30 a. m. to 1 p. m.
- 1918 Dexter, Roderick B., M. D., Assistant Physician Boston State Hospital, Boston, Mass. (*Associate.*)
- 1913 Dexter, Roger, M. D., Assistant Physician Dannemora State Hospital, Dannemora, N. Y. (*Associate.*)
- 1900 Diefendorf, Allen Ross, M. D., 29 College St., New Haven, Conn.
- 1912 Dobson, Wm. M., M. D., Boston State Hospital, Dorchester Centre, Mass. (*Associate.*)
- 1912 Dodge, Percy L., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1907 Doherty, Charles E., M. D., Superintendent Public Hospital for Insane, New Westminster, B. C., Canada.
- 1892 Dold, William E., M. D., Physician-in-Charge River Crest Sanitarium, Astoria, L. I., N. Y. 616 Madison Ave., New York City.
- 1918 Dollear, Albert H., M. D., Assistant Physician Jacksonville State Hospital, Jacksonville, Ill.
- 1908 Dolloff, Charles H., M. D., Superintendent New Hampshire State Hospital, Concord, N. H. (*Associate.*)
- 1917 Donnet, John V., M. D., Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)
- 1908 Donohoe, George, M. D., Superintendent Cherokee State Hospital, Cherokee, Iowa.
- 1902 Douglas, A. E., M. D., Superintendent Highland Sanitarium, R. F. D. No. 7, Nashville, Tenn.

- 1916 Douglas, Gilbert F., M. D., 26 W. 60th St., New York, N. Y. (*Associate.*)
- 1918 Dowell, Raymond F., M. D., Assistant Physician, Elgin State Hospital, Elgin, Ill. (*Associate.*)
- 1907 Downing, Dana Fletcher, M. D., Assistant Physician Westborough State Hospital, Westborough, Mass.
- 1892 Drewry, William F., M. D., Medical Superintendent Central State Hospital, Petersburg, Va. (*President, 1910.*)
- 1915 Drysdale, H. H., M. D., Rose Bldg., Cleveland, Ohio.
- 1917 Duke, John W., M. D., Chairman State Commission in Lunacy, Guthrie, Okla.
- 1914 Dunham, Sydney A., M. D., Resident Physician and Proprietor Dr. Dunham's Sanitarium, 1392 Amherst St., Buffalo, N. Y.
- 1896 Dunton, Wm. Rush, Jr., M. D., First Assistant Physician Sheppard and Enoch Pratt Hospital, Towson, Md.
- 1912 Durgin, Delmer D., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1899 Durham, Albert, M. D., Piedmont Bldg., Charlotte, N. C. (*Associate.*)
- 1917 Dykman, Augustus B., M. D., Riverdale Sanitarium, West Hill, Riverdale, N. Y. (*Associate.*)

## E

- 1909 Earl, H. D., M. D., First Assistant Physician North Dakota State Hospital, Jamestown, N. D.
- 1912 Eastman, Frederic C., M. D., 1268 Bergen St., Brooklyn, N. Y.
- 1912 Eaton, Richard G., M. D., Assistant Superintendent Cherokee State Hospital, Cherokee, Ia. (*Associate.*)
- 1914 Eckel, John L., M. D., 145 Allen St., Buffalo, N. Y.
- 1915 Eckerdt, A. Burton, M. D., Helena, Mont. (*Associate.*)
- 1896 Edenharter, Geo. F., M. D., Medical Superintendent Central Indiana Hospital for the Insane, Indianapolis, Ind.
- 1893 Edgerly, J. Frank, M. D., Lincoln, Mass.
- 1894 Edwards, John B., M. D. (formerly Medical Superintendent Wisconsin State Hospital), 311 Goldsmith Building, Milwaukee, Wis.
- 1917 Eichelberger, William W., M. D., Waukesha Springs Sanitarium, Waukesha, Wis. (*Associate.*)
- 1913 Eirley, Clara, M. D., State Hospital, Mt. Pleasant, Iowa. (*Associate.*)
- 1897 Elliott, Robert M., M. D., Medical Superintendent Willard State Hospital, Willard, N. Y.
- 1915 Ellison, Wm. A., M. D., 36 E. Merritt Ave., Atlanta, Ga. (*Associate.*)
- 1913 Emerick, E. J., M. D., Superintendent Institution for Feeble-Minded, Columbus, O.
- 1913 Emerson, Ernest B., M. D., Superintendent Rutland Sanatorium, Rutland, Mass.

- 1892 Emerson, Justin E., M. D., Box 909, St. Petersburg, Fla.  
 1915 Ende, Edward H., M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)  
 1917 Engberg, Edward J., M. D., Teacher Nervous and Mental Diseases University of Minnesota, St. Paul, Minn.  
 1909 English, W. M., M. D., Medical Superintendent Hospital for Insane, Hamilton, Ont.  
 1893 Evans, B. D., M. D., Medical Director New Jersey State Hospital, Morris Plains, N. J.  
 1918 Evans, Mary L., M. D., Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)  
 1915 Evans, T. W., M. D., East Louisiana Hospital for the Insane, Jackson, La. (*Associate.*)  
 1914 Evarts, Arrah B., M. D., Assistant Physician State Hospital, Rochester, Minn.  
 1908 Everett, Edward A., M. D., Superintendent Cornwall Sanitarium, Cornwall-on-Hudson, N. Y.  
 1912 Ewing, Hallie Laura, M. D., Assistant Physician Nebraska Hospital for Insane, Lincoln, Neb. (*Associate.*)  
 1892 Eyman, H. C., M. D., Massillon, O. (*Vice-President.*)

## F

- 1907 Faison, W. W., M. D., Superintendent State Hospital, Goldsboro, N. C.  
 1918 Farmer, Winfield S., M. D., Superintendent Central Hospital for the Insane, Nashville, Tenn.  
 1917 Farrington, Charlotte S., M. D., Philadelphia, Pa.  
 1916 Farrington, E. A., M. D., Bancroft School for Feeble-Minded Youth, Haddonfield, N. J.  
 1918 Fast, William S., M. D., Nebraska State Hospital, Ingleside, Nebr.  
 1912 Faxon, Dora W., M. D., Boston State Hospital, Dorchester Center, Mass. (*Associate.*)  
 1916 Fell, Egbert W., M. D., Clinical Director Cincinnati Sanitarium, Cincinnati, O. (*Associate.*)  
 1918 Ferguson, K. M., M. D., Assistant Physician Massillon State Hospital, Massillon, O. (*Associate.*)  
 1895 Fernald, Walter E., M. D., Superintendent Massachusetts School for the Feeble-Minded, Waverley, Mass.  
 1909 Ferris, Albert Warren, M. D., The Glen Springs, Watkins, N. Y.  
 1913 Finlayson, Alan D., M. D., Senior Assistant Physician Warren State Hospital, Warren, Pa.  
 1915 Fischbein, Elias, M. D., Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y. (*Associate.*)  
 1912 Fish, Drury L., M. D., Kankakee State Hospital, Hospital, Ill. (*Associate.*)  
 1907 Fisher, E. Moore, M. D., Senior Assistant Physician New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)

- 1892 **Fitzgerald, John F., M. D.**, General Medical Superintendent, King's County Hospital, Brooklyn, N. Y.
- 1912 **Fletcher, Christopher, M. D.**, Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)
- 1900 **Flood, Everett, M. D.**, Superintendent Monson State Hospital, Palmer, Mass.
- 1912 **Foley, Edward A., M. D.**, Assistant Physician State Hospital, Watertown, Ill. (*Associate.*)
- 1915 **Folsom, Ralph P., M. D.**, Senior Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1916 **Ford, Walter A., M. D.**, Assistant Physician State Hospital, Jacksonville, Ill. (*Associate.*)
- 1911 **Fordyce, O. O., M. D.**, Superintendent Athens State Hospital, Athens, O.
- 1913 **Forster, James M., M. D.**, Medical Superintendent Hospital for Insane, Toronto, Ont.
- 1915 **Fort, S. J., M. D.**, Baltimore, Md.
- 1916 **Fougerousse, Henry L., M. D.**, Assistant Physician Louisiana Hospital for Insane, Pineville, La. (*Associate.*)
- 1915 **Francisco, Howard M., M. D., M. R. C., U. S. Army.** (*Associate.*)
- 1908 **Franz, Shepherd I., A. B., Ph. D.**, Scientific Director St. Elizabeth Hospital, Washington, D. C. (*Honorary.*)
- 1917 **Frazer, B. F., M. D.**, Assistant Physician Osawatomic State Hospital, Osawatomic, Kans. (*Associate.*)
- 1913 **Freeman, George H., M. D.**, Superintendent State Hospital for Inebriates, Willmar, Minn.
- 1897 **French, Edward, M. D.**, 135 Cheswick Road, Brighton, Mass.
- 1914 **Frink, Horace W., M. D.**, 1 W. 83d St., New York, N. Y.
- 1913 **Fuller, Daniel H., M. D.**, Senior Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.
- 1902 **Fuller, Solomon Carter, M. D.**, Pathologist Westborough State Hospital, Westborough, Mass.
- 1916 **Fulmer, Joseph C., M. D.**, Assistant Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa. (*Associate.*)
- 1908 **Funkhouser, Edgar B., M. D.**, Second Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)
- 1914 **Furman, Isaac J., M. D.**, Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)

## G

- 1918 **Gable, James J., M. D., M. C., U. S. A.** (*Associate.*)
- 1917 **Gahagan, Henry J., M. D.**, 1448 Peoples Gas Bldg., Chicago, Ill.
- 1916 **Gaines, Lewis M., M. D.**, Atlanta, Ga.
- 1911 **Gale, George Bancroft, M. D.**, 457 Mt. Prospect Ave., Newark, N. J.

- 1913 Gardner, Wm. E., M. D., Louisville Neuropathic Sanatorium, Louisville, Ky.
- 1905 Garrett, R. Edward, M. D., Assistant Physician Maryland Hospital for the Insane, Catonsville, Md. (*Associate.*)
- 1915 Garvin, Wm. C., M. D., Senior Assistant Physician Manhattan State Hospital, Wards Island, N. Y. (*Associate.*)
- 1909 George, John Cecil, M. D., Orchard Springs Sanitarium, Dayton, Ohio. (*Associate.*)
- 1912 Gearegen, Wm. E., M. D., Resident Physician Belle Mead Farm Colony and Sanatorium, Belle Mead, N. J.
- 1917 Gibson, Edward T., M. D., Clinical Director Connecticut Hospital for Insane, Middletown, Conn. (*Associate.*)
- 1914 Gibson, Horatio G., Jr., M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
- 1909 Gillespie, Edward, M. D., Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)
- 1917 Gilfillan, Donald R., M. D., Assistant Physician Worcester State Hospital, Worcester, Mass. (*Associate.*)
- 1915 Gillis, Andrew C., M. D., 924 N. Charles St., Baltimore, Md.
- 1893 Givens, A. J., M. D., Proprietor Dr. Givens' Sanitarium, Stamford, Conn.
- 1895 Givens, John W., M. D., Medical Superintendent Northern Idaho Insane Asylum, Orofino, Idaho.
- 1914 Glueck, Bernard, M. D., P. O. Box 143, Ossining, N. Y. (*Associate.*)
- 1916 Goff, A. P., M. D., Chief San Lazaro Hospital, Manilla, P. I.
- 1903 Goodwill, V. L., M. D., 84 York St., Charlottetown, P. E. I.
- 1912 Gordon, Alfred, M. D., 1812 Spruce St., Philadelphia, Pa.
- 1906 Gorst, Charles, M. D., 707 Irving Park Boulevard, Chicago, Ill.
- 1915 Gosline, Harold I., M. D., Assistant Physician New Jersey State Hospital, Trenton, N. J.
- 1898 Goss, Arthur V., M. D., Superintendent Taunton State Hospital, Taunton, Mass.
- 1886 Granger, Wm. D., M. D., Vernon House, Bronxville, N. Y.
- 1905 Green, Edward M., M. D., Superintendent Harrisburg State Hospital, Harrisburg, Pa.
- 1909 Greene, Edward C., M. D., Northampton State Hospital, Northampton, Mass. (*Associate.*)
- 1910 Greene, James L., M. D., Hot Springs, Ark.
- 1916 Greene, Ralph N., M. D., Chattahoochee, Fla.
- 1917 Greenwood, James, M. D., President Dr. Greenwood's Sanitarium, Houston, Tex.
- 1914 Gregg, Donald, M. D., Associate Physician Channing Sanitarium, Brookline, Mass.

- 1917 Gregory, Hugh S., M.D., Senior Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
- 1908 Gregory, Menas S., M.D., Resident Alienist Bellevue Hospital, New York, N. Y.
- 1913 Griffin, D. W., M.D., Superintendent Oklahoma State Hospital, Norman, Okla.
- 1913 Groom, Wirt C., M.D., Assistant Physician Willard State Hospital, Willard, N. Y. (*Associate.*)
- 1914 Grover, Milton M., M.D., Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1910 Guilford, Alberta S. B., M.D., 512 Albany Building, Boston, Mass.
- 1900 Gundry, Alfred T., M.D., Medical Director The Gundry Sanitarium, Catonsville, Md.
- 1908 Gundry, Lewis H., M.D., Superintendent Relay Sanitarium, Relay, Baltimore Co., Md.
- 1892 Gundry, Richard F., M.D., Medical Director and Proprietor the Richard Gundry Home, Harlem Lodge, Catonsville, Md.
- 1899 Guthrie, L. V., M.D., Superintendent Huntington State Hospital, Huntington, W. Va.

## H

- 1914 Haberman, J. Victor, M.D., 60 West 85th St., New York, N. Y.
- 1917 Hackett, John F., M.D., Assistant Physician Colony for Epileptics, Mansfield Depot, Conn. (*Associate.*)
- 1916 Haines, Thomas H., M.D., Professor Nervous and Mental Diseases Ohio State University, Columbus, O.
- 1891 Hall, G. Stanley, Ph.D., LL.D., President Clark University, Worcester, Mass. (*Honorary.*)
- 1886 Hall, Henry C., M.D., Assistant Superintendent Butler Hospital, Providence, R. I. (*Associate.*)
- 1915 Hall, Jas. K., M.D., Resident Physician Westbrook Sanatorium, Richmond, Va.
- 1916 Halterman, Charles W., M.D., Clarksburg, W. Va.
- 1899 Hamilton, Arthur S., M.D., Instructor in Nervous and Mental Diseases and Neuropathology, College of Medicine and Surgery, University of Minnesota, 513 Pillsbury Building, Minneapolis, Minn.
- 1907 Hamilton, Gilbert V., M.D., San Marcos Building, Santa Barbara, Cal.
- 1907 Hamilton, Samuel W., M.D., Senior Assistant Physician Utica State Hospital, Utica, N. Y.
- 1912 Hammers, James S., M.D., 1309 Biltmore Ave., Pittsburg, Pa. (*Associate.*)
- 1917 Hammes, Ernest M., M.D., Teacher Nervous and Mental Diseases University of Minnesota, St. Paul, Minn.

- 1908 **Hammond, Graeme M., M. D.**, Professor of Mental Diseases, 60 W. 56th St., New York, N. Y.
- 1893 **Hancker, W. H., M. D.**, Medical Superintendent Delaware State Hospital, Farnhurst, Del.
- 1906 **Hanes, Edward L., M. D.**, 748 Main St., E., Rochester, N. Y.
- 1913 **Hanson, Wm. T., M. D.**, Mass. State Infirmary, Tewksbury, Mass. (*Associate.*)
- 1904 **Harding, George T., Jr., M. D.** (Neurologist to Grant Hospital, St. Anthony's Hospital and St. Clair Hospital), 318 E. State St., Columbus, O.
- 1918 **Harner, Blanche W., M. D.**, Assistant Physician Rochester State Hospital, Rochester, Minn. (*Associate.*)
- 1894 **Harrington, Arthur H., M. D.**, Superintendent State Hospital for Insane, Howard, R. I.
- 1918 **Harris, Ada E., M. D.**, Pathologist Worcester State Hospital, Worcester, Mass. (*Associate.*)
- 1899 **Harris, Isham G., M. D.**, Superintendent Brooklyn State Hospital, Brooklyn, N. Y.
- 1888 **Harrison, Daniel A., M. D.**, Breezehurst Terrace, Whitestone, L. I., N. Y.
- 1915 **Haskell, Robt. Henry, M. D.**, Superintendent Ionia State Hospital, Ionia, Mich.
- 1913 **Hasking, Arthur P., M. D.**, Official Examiner of Indigent Insane, Hudson Co., 318 Montgomery St., Jersey City, N. J.
- 1914 **Hassall, James C., M. D.**, Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)
- 1910 **Hatch, F. W., M. D.**, General Superintendent of California State Hospitals, Sacramento, Cal.
- 1913 **Hatcher, George E., M. D.**, Cerulean, Ky.
- 1894 **Hattie, W. H., M. D.**, Inspector of Humane and Penal Institutions, Halifax, N. S.
- 1899 **Haviland, C. Floyd, M. D.**, Superintendent State Hospital, Middletown, Conn.
- 1918 **Haviland, F. Ross, M. D.**, Senior Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1914 **Haviland, Walter C., M. D.**, 11 Elm St., Worcester, Mass.
- 1908 **Hawke, W. W., M. D.**, "The Eyrie," Clifton Heights, Delaware Co., Pa.
- 1915 **Hawkins, G. G., M. D.**, First Assistant Physician Eastern State Hospital, Williamsburg, Va. (*Associate.*)
- 1916 **Hawley, N. C., M. D.**, Assistant Superintendent Elgin State Hospital, Elgin, Ill. (*Associate.*)
- 1910 **Hedin, Carl J., M. D.**, Superintendent Maine School for Feeble-Minded, W. Pownal, Me.
- 1918 **Helberg, Elizabeth S., M. D.**, Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)

- 1912 Helmer, Ross D., M.D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1915 Henderson, David Kennedy, M.D., Resident Psychiatrist, Phipps Clinic, Johns Hopkins Hospital, Baltimore, Md. (*Associate.*) (Present address, Royal Asylum, Gartnavel, Glasgow, Scotland.)
- 1913 Henderson, Estelle H., M.D., Superintendent Southwestern State Hospital, Marion, Va.
- 1912 Henry, Hugh Carter, M.D., First Assistant Physician Central State Hospital, Petersburg, Va. (*Associate.*)
- 1911 Henschel, Louis K., M.D., 288 E. 161st St., New York, N. Y. (*Associate.*)
- 1918 Herrin, Herbert E., M.D., First Assistant Physician New Hampshire State Hospital, Concord, N. H. (*Associate.*)
- 1911 Herring, Arthur P., M.D., Secretary State Lunacy Commission, 330 N. Charles St., Baltimore, Md.
- 1894 Heyman, Marcus B., M.D., Superintendent Manhattan State Hospital, Wards Island, N. Y.
- 1911 Hickling, D. Percy, M.D., Alienist of District of Columbia, 1304 Rhode Island Ave., N.W., Washington, D. C.
- 1916 Hicks, H. E., M.D., Assistant Superintendent Brandon Asylum, Brandon, Manitoba. (*Associate.*)
- 1917 Hill, Charles B., M.D., Superintendent Oklahoma Hospital for Insane, Supply, Okla.
- 1883 Hill, Chas. G., M.D., Physician-in-Chief Mt. Hope Retreat, Baltimore, Md. (*President, 1907.*)
- 1883 Hill, Gershom H., M.D., Superintendent "The Retreat," Des Moines, Ia.
- 1916 Hill, Ralph L., M.D., Superintendent Allegheny Hospital for Insane, Woodville, Pa.
- 1899 Hill, S. S., M.D., Superintendent State Asylum for the Chronic Insane, Wernersville, Pa.
- 1886 Hinckley, L. S., M.D. (formerly Medical Superintendent Essex County Hospital), 182 Clinton Ave., Newark, N. J.
- 1913 Hinton, Ralph T., M.D., Superintendent Elgin State Hospital, Elgin, Ill.
- 1900 Hirsch, Wm., M.D., Neurologist to the German Poliklinik, 52 E. 64th St., New York, N. Y.
- 1916 Hiscock, Robt. C., M.D., Assistant Physician Protestant Hospital, Verdun, Que. (*Associate.*)
- 1900 Hitchcock, Chas. W., M.D., Attending Neurologist Harper Hospital, 1501 David Whitney Building, Detroit, Mich.
- 1903 Hobbs, Alfred T., M.D., Superintendent Homewood Sanitarium, Guelph, Ont.
- 1895 Hoch, August, M.D., Riven Rock, Santa Barbara, Cal.
- 1904 Hoch, Theodore A., M.D., Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)



- 1914 **Hodakin, Morgan B., M. D.**, Assistant Physician Monson State Hospital, Palmer, Mass. (*Associate.*)
- 1914 **Hoffman, Harry F., M. D.**, Assistant Superintendent Homeopathic State Hospital, Allentown, Pa. (*Associate.*)
- 1917 **Hoisholt, Andrew W., M. D.**, Superintendent Napa State Hospital, Napa, Cal.
- 1915 **Holbrook, Chas. S., M. D.**, Assistant Physician Eastern La. Hospital for the Insane, Jackson, La. (*Associate.*)
- 1900 **Holley, Erving, M. D.**, Assistant Physician Long Island State Hospital, Brooklyn, N. Y. (*Associate.*)
- 1915 **Holt, Earl K., M. D.**, Assistant Physician Hospital for the Insane, Logansport, Ind. (*Associate.*)
- 1916 **Horger, E. L., M. D.**, Pathologist State Hospital, Columbia, S. C. (*Associate.*)
- 1913 **Horsman, Hiram L., M. D.**, Assistant Physician Grafton State Hospital, Worcester, Mass. (*Associate.*)
- 1913 **Hotchkiss, W. M., M. D.**, Superintendent State Hospital for Insane, Jamestown, N. Dak.
- 1894 **Houston, John A., M. D.**, Medical Superintendent Northampton State Hospital, Northampton, Mass.
- 1894 **Howard, A. B., M. D.** (formerly Medical Superintendent Cleveland State Hospital), 736 Rose Building, Cleveland, Ohio.
- 1888 **Howard, Eugene H., M. D.**, Medical Superintendent Rochester State Hospital, Rochester, N. Y.
- 1912 **Hubbard, O. S., M. D.**, Superintendent Kansas State Hospital for Epileptics, Parsons, Kans. (*Associate.*)
- 1907 **Hummer, Henry R., M. D.**, Superintendent Asylum for Insane Indians, Canton, S. Dak.
- 1899 **Hun, Henry, M. D.**, Albany, N. Y. (*Honorary.*)
- 1916 **Hunnicutt, Wm. P., M. D.**, Assistant Physician Colorado Insane Asylum, Pueblo, Colo. (*Associate.*)
- 1894 **Hurd, Arthur W., M. D.**, 228 Summer St., Buffalo, N. Y.
- 1879 **Hurd, Henry M., M. D.**, Secretary Johns Hopkins Hospital, 1023 St. Paul St., Baltimore, Md. (*President, 1899.*)
- 1897 **Hutchings, Richard H., M. D.**, Medical Superintendent Utica State Hospital, Utica, N. Y.
- 1899 **Hutchinson, Anna E., M. D.**, Woman Assistant Physician Manhattan State Hospital, Ward's Island, New York, N. Y. (*Associate.*)
- 1885 **Hutchinson, Henry A., M. D.**, Medical Superintendent The Dixmont Hospital for the Insane, Dixmont, Pa.
- 1917 **Hyde, Arthur G., M. D.**, Superintendent Massillon State Hospital, Massillon, O.
- 1916 **Hyde, Geo. E., M. D.**, Medical Superintendent Utah State Mental Hospital, Provo, Utah.

## I

- 1901 Inch, Geo. Franklin, M. D., Assistant Medical Superintendent Kalamazoo State Hospital, Kalamazoo, Mich. (*Associate.*)  
 1913 Ingram, Robert, M. D., Neurologist Cincinnati Hospital, Cincinnati, O.  
 1912 Isham, Mary Keyt, M. D., 135 W. 79th St., New York, N. Y.

## J

- 1913 Jackson, J. Allen, M. D., Chief Resident Physician Philadelphia Hospital for Insane, Philadelphia, Pa.  
 1912 Jacobs, Wilma H., M. D., Watertown State Hospital, East Moline, Ill. (*Associate.*)  
 1913 Jacoby, J. Ralph, M. D., 54 W. 88th St., New York, N. Y.  
 1916 James, C. E., M. D., Massillon State Hospital, Massillon, O. (*Associate.*)  
 1908 Jelliffe, Smith Ely, M. D., Visiting Neurologist City Hospital, 64 W. 56th St., New York, N. Y.  
 1903 Jelly, Arthur C., M. D., 10 Arlington St., Boston, Mass.  
 1917 Jewett, Stephen P., M. D., 1200 Madison Ave., New York, N. Y. (*Associate.*)  
 1918 Jones, Bertrand L., M. D., Assistant Director State Psychopathic Hospital, Ann Arbor, Mich. (*Associate.*)  
 1915 Jones, Kenneth B., M. D., Rosewood State Training School, Owings Mills, Md.  
 1909 Jones, L. M., M. D., Superintendent Georgia State Sanitarium, Milledgeville, Ga.  
 1915 Jones, Wm. A., M. D., 406 Physicians and Surgeons Building, Minneapolis, Minn.  
 1909 Jordan, M. M., M. D., Assistant Physician Westborough State Hospital, Westborough, Mass. (*Associate.*)

## K

- 1918 Kauffman, Lesser, M. D., 534 Elmwood Ave., Buffalo, N. Y.  
 1915 Keating, Frank W., M. D., Superintendent Rosewood School for Feeble-Minded, Owings Mills, Md.  
 1914 Keatley, Harry W., M. D., Huntington, West Va. (*Associate.*)  
 1917 Kehoe, H. C., M. D., Flemingsburg, Ky.  
 1918 Kelleher, James P., M. D., Senior Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)  
 1872 Kellogg, Theo. H., M. D., Riverdale Lane and Albany Post Road, Riverdale, New York, N. Y.  
 1913 Kelly, Wm. E., M. D., Assistant Physician Middletown State Homeopathic Hospital, Middletown, N. Y. (*Associate.*)  
 1914 Kempf, Edward J., M. D., Clinical Psychiatrist St. Elizabeth Hospital, Washington, D. C. (*Associate.*)

- 1915 **Kempf, Grover A., M. D.**, Assistant Surgeon United States Public Health Service, Ellis Island, N. Y.
- 1915 **Kenworthy, Marion E., M. D.**, Senior Assistant Physician Foxborough State Hospital, Foxborough, Mass. (*Associate.*)
- 1918 **Kenyon, Howard M., M. D.**, 749 Myrtle Ave., Albany, N. Y. (*Associate.*)
- 1912 **Kern, W. B., M. D.**, Medical Superintendent Norwalk State Hospital, Norwalk, Cal.
- 1910 **Kieb, Raymond F. C., M. D.**, Superintendent Matteawan State Hospital, Beacon, N. Y.
- 1890 **Kilbourne, Arthur F., M. D.**, Medical Superintendent Rochester State Hospital, Rochester, Minn. (*President, 1909.*)
- 1895 **Kindred, J. J., M. D.**, Proprietor and Consulting Physician of the River Crest Sanitarium, Astoria, L. I., N. Y.
- 1913 **Kineon, G. G., M. D.**, Superintendent Ohio Hospital for Epileptics, Gallipolis, O.
- 1917 **King, Cheston, M. D.**, Cheston King Sanitarium, Atlanta, Ga.
- 1908 **King, George W., M. D.**, Medical Director Hudson County Hospital for Insane, Secaucus, N. J.
- 1912 **King, Robert, M. D.**, Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)
- 1914 **Kingsley, Alfred C., M. D.**, Superintendent Arizona State Hospital, Phoenix, Ariz.
- 1901 **Kinney, C. Spencer, M. D.**, Proprietor Easton Sanitarium, Easton, Pa.
- 1910 **Kirby, George H., M. D.**, Director Psychiatric Institute, Ward's Island, New York, N. Y.
- 1918 **Kirk, C. C., M. D.**, Superintendent Arkansas State Hospital, Little Rock, Ark.
- 1905 **Kline, George M., M. D.**, Director Massachusetts Commission on Mental Diseases, State House, Boston, Mass.
- 1900 **Klopp, Henry I., M. D.**, Superintendent Homeopathic State Hospital, Allentown, Pa.
- 1899 **Knapp, John Rudolph, M. D.**, Assistant Physician Manhattau State Hospital, Ward's Island, New York, N. Y. (*Associate.*)
- 1918 **Kradwell, William T., M. D.**, Assistant Physician Milwaukee Sanitarium, Wauwatosa, Wis.
- 1902 **Kuhlman, Helene J. C., M. D.**, Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)

## L

- 1901 **Lamb, Robert B., M. D.**, Craig House, Beacon-on-Hudson, N. Y.
- 1917 **Lambert, Charles L., M. D.**, Assistant Physician Bloomingdale Hospital, White Plains, N. Y. (*Associate.*)

- 1900 La Moure, Chas. T., M. D., Superintendent Mansfield State Training School and Hospital, Mansfield Depot, Conn.
- 1911 La Moure, Howard A., M. D., Superintendent Colorado State Insane Asylum, Pueblo, Col.
- 1908 Landers, George B., M. D., Superintendent Morristown Memorial Hospital, Morristown, N. J. (*Associate.*)
- 1912 Lane, Arthur G., M. D., Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
- 1892 Lane, Edward B., M. D., Resident Physician Adams Nervine Asylum, 419 Boylston St., Boston, Mass.
- 1913 Lang, Walter E., M. D., Senior Assistant Physician Homeopathic State Hospital, Allentown, Pa. (*Associate.*)
- 1903 Langdon, F. W., M. D., Medical Director Cincinnati Sanitarium; Professor of Psychiatry, University of Cincinnati, 4003 Rose Hill Ave., Cincinnati, Ohio.
- 1918 LaRue, F. G., M. D., Superintendent Western Kentucky Asylum for the Insane, Hopkinsville, Ky.
- 1906 Laughlin, Charles E., M. D., Superintendent Southern Indiana Hospital for the Insane, Evansville, Ind.
- 1907 Lawlor, Fred E., M. D., Superintendent Nova Scotia Hospital, Halifax, N. S.
- 1882 Lawton, Shailer E., M. D., Medical Superintendent Brattleboro Retreat, Brattleboro, Vt.
- 1911 Leader, Pauline M., M. D., Woman Physician Clarinda State Hospital, Clarinda, Iowa. (*Associate.*)
- 1912 Leahy, Sylvester R., M. D., Resident Alienist Kings Co. Hospital, Brooklyn, N. Y.
- 1901 Leak, Roy L., M. D., Medical Director State Hospital, Columbia, S. C.
- 1912 Leavitt, William, M. D., Assistant Physician Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
- 1917 Leonard, Christine, M. D., Assistant Physician Municipal Courts, Boston, Mass. (*Associate.*)
- 1913 Leonard, Edward F., M. D., 3501 N. Hermitage Ave., Chicago, Ill.
- 1913 Levin, Hyman L., M. D., Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
- 1900 Lewis, J. M., M. D. (formerly Superintendent Cleveland State Hospital), 436 Rose Bldg., Cleveland, Ohio.
- 1914 Lind, John E., M. D., Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)
- 1918 Lindsay, Marie S., M. D., Assistant Physician Worcester State Hospital, Worcester, Mass. (*Associate.*)
- 1910 Lindsay, S. C., M. D., Capt. M. R. C., U. S. Army. (*Associate.*)
- 1917 Lindsay, William S., M. D., Christ's Hospital Cottages, Topeka, Kans.

- 1915 Llewellyn, G. S., M. D., First Assistant Physician Pittsburgh City Home, Marshalsea, Boyce, Pa. (*Associate.*)
- 1915 Locke, Hersey G., M. D., 608 E. Genessee St., Syracuse, N. Y.
- 1909 Long, T. L., M. D., State Colony for Epileptics, Woodward, Ia.
- 1911 Lorenz, William F., M. D., Director of Psychiatric Institute, Mendota, Wis. (*Associate.*)
- 1909 Love, George R., M. D., Superintendent Toledo State Hospital, Toledo, Ohio.
- 1913 Lowe, Charles R., M. D., Lincoln State School and Colony, Lincoln, Ill. (*Associate.*)
- 1903 Ludlum, Seymour DeWitt, M. D., Merion, Pa. (*Associate.*)
- 1912 Lustig, Daniel D., M. D., 146 Grant Ave., San Francisco, Cal.
- 1913 Lyon, Charles G., M. D., Superintendent Dr. Lyon's Sanitarium, Binghamton, N. Y.
- 1882 Lyon, Samuel B., M. D., The Mansfield, 12 W. 44th St., N. Y.

## M

- 1894 McBride, James H., M. D., 489 Bellefontaine St., Pasadena, Cal.
- 1909 McCafferty, Emit L., M. D., Assistant Superintendent Mt. Vernon Hospital, Mt. Vernon, Ala.
- 1910 McCampbell, John, M. D., Superintendent State Hospital, Morganton, N. C.
- 1909 McCarthy, D. J., M. D., Professor of Medical Jurisprudence University of Pennsylvania and Woman's Medical College, Philadelphia, Pa.
- 1916 McCloud, J. J., M. D., Assistant Physician Institution for Feeble-Minded, Columbus, O. (*Associate.*)
- 1917 McDaniel, Fred L., M. D., Assistant Physician Osawatomie State Hospital, Osawatomie, Kans. (*Associate.*)
- 1903 McDonald, William, Jr., M. D., 188 Blackstone Boulevard, Providence, R. I.
- 1915 McFadden, Jas. F., M. D., G. H. 41, Fox Hills, Staten Island, N. Y. (*Associate.*)
- 1909 McGaffin, Charles Gibson, M. D., Pathologist and Assistant Physician Kings Park State Hospital, Kings Park, N. Y.
- 1911 McKay, James G., M. D., Royal Bank Chambers, New Westminster, B. C. (*Associate.*)
- 1905 McKelway, John Irvine, M. D., Second Assistant Superintendent Eastern Oregon State Hospital, Pendleton, Ore.
- 1907 McKinnisa, Clyde R., M. D., Superintendent Pittsburgh City Hospital, Boyce Station, Pa.
- 1917 McPherson, George E., M. D., Assistant Superintendent Medfield State Hospital, Medfield, Mass. (*Associate.*)

- 1915 **MacCurdy, John T., M. D.**, Assistant Physician Psychiatric Institute, New York City.
- 1874 **MacDonald, Carlos F., M. D.**, 15 E. 48th St., New York, N. Y. (*President, 1914.*)
- 1914 **Macdonald, John B., M. D.**, Superintendent Danvers State Hospital, Hathorne, Mass.
- 1915 **MacDonald, Thos. D., M. D.**, Assistant Physician Dr. MacDonald's House, Central Valley, N. Y. (*Associate.*)
- 1917 **MacIntyre, Wm. A., M. D.**, Assistant Physician State Infirmary Tewksbury, Mass. (*Associate.*)
- 1915 **MacIver, Geo. A., M. D.**, Assistant Resident Physician Massachusetts General Hospital, Boston, Mass. (*Associate.*)
- 1918 **MacKenzie, Alex. R., M. D.**, Assistant Physician Huntington State Hospital, Huntington, W. Va. (*Associate.*)
- 1913 **Mack, Clifford W., M. D.**, Livermore Sanitarium, Livermore, Cal.
- 1907 **Mackin, M. Charles, M. D.**, Superintendent State Hospital for Inebriates, Knoxville, Ia.
- 1918 **MacLachlan, Mary, M. D.**, Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)
- 1912 **MacNaughton, Peter, M. D.**, Assistant Superintendent Hospital for Insane, Hamilton, Ont. (*Associate.*)
- 1916 **MacNiell, James W., M. D.**, Superintendent Provincial Hospital, Battleford, Saskatchewan.
- 1917 **MacPhee, Catherine, M. D.**, Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)
- 1918 **Maginnis, F. N., M. D.**, Assistant Superintendent Mercyville Sanitarium, Aurora, Ill. (*Associate.*)
- 1912 **Malberti, José A., M. D.**, Malberti's Sanitarium, Havana, Cuba.
- 1900 **Manton, Walter P., M. D.**, Gynecologist Eastern and Northern Michigan Asylums; Consulting Gynecologist St. Joseph's Retreat, 32 Adams Ave., West, Detroit, Mich.
- 1915 **Markham, Convas L., M. D.**, Superintendent Brunswick Home, Amityville, N. Y.
- 1915 **Mason, B. Henry, M. D.**, First Assistant Physician Worcester State Hospital, Worcester, Mass. (*Associate.*)
- 1911 **Matthews, Adelbert C., M. D.**, First Assistant Physician Napa State Hospital, Napa, Cal.
- 1912 **Matzinger, Herman G., M. D.**, 90 Soldier's Place, Buffalo, N. Y.
- 1904 **Maxfield, Geo. H., M. D.**, Soldiers' Home, Chelsea, Mass. (*Associate.*)
- 1912 **May, Herman F., M. D.**, Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)
- 1910 **May, James V., M. D.**, Superintendent Boston State Hospital, Dorchester Center, Mass.
- 1894 **Mayberry, Chas. B., M. D.**, Superintendent Hospital for the Insane of the Central Poor District of Luzerne County, Retreat, Luzerne Co., Pa.

- 1902 **Mayer, Edward E., M.D.**, Clinical Professor of Neurology University of Pittsburgh, Keenan Bldg., Pittsburgh, Pa.
- 1893 **Mead, Leonard C., M.D.**, Medical Superintendent South Dakota Hospital for the Insane, Yankton, S. D.
- 1917 **Means, P. B., M.D.**, Assistant Physician New Jersey State Hospital, Trenton, N. J. (*Associate.*)
- 1912 **Mellus, Edward, M.D.**, Superintendent Dr. Mellus' Private Hospital, 419 Waverley Ave., Newton, Mass.
- 1918 **Melvin, George M., M.D.**, Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)
- 1891 **Meredith, Hugh B., M.D.**, Medical Superintendent State Hospital for the Insane, Danville, Pa.
- 1912 **Merriman, Willis E., M.D.**, Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1893 **Meyer, Adolf, M.D.**, Professor of Psychiatry Johns Hopkins University, 101 Edgevale Road, Roland Park, Md.
- 1914 **Mikels, Frank M., M.D.**, 631 1st National Bank Bldg., Long Beach, Cal. (*Associate.*)
- 1915 **Miller, F. B. E., M.D.**, Assistant Physician State Hospital for the Insane, Cherokee, Iowa. (*Associate.*)
- 1904 **Miller, Henry W., M.D.**, "Mountainbrook," Brewster, N. Y.
- 1917 **Miller, S. Metz, M.D.**, Chief Resident Physician State Hospital, Norristown, Pa.
- 1916 **Milligan, James W., M.D.**, Medical Superintendent Southeastern Hospital, Madison, Ind.
- 1893 **Mills, Chas. K., M.D.**, Professor of Neurology University of Pennsylvania, 1909 Chestnut St., Philadelphia, Pa.
- 1918 **Mills, George W. T., M.D.**, Director Clinical Psychiatry Central Islip State Hospital, Central Islip, N. Y. (*Associate.*)
- 1915 **Mills, Harlan P., M.D.**, Box 1328, Phoenix, Ariz. (*Associate.*)
- 1907 **Millsbaugh, Daniel T., M.D.**, Superintendent "Riverlawn," 47 Totowa Ave., Paterson, N. J.
- 1899 **Mitchell, H. W., M.D.**, Superintendent Warren State Hospital, Warren, Pa. (*Secretary-Treasurer.*)
- 1912 **Mitchell, John C., M.D.**, Superintendent Hospital for the Insane, Brockville, Ont.
- 1908 **Mitchell, Roy E., M.D.**, Boberg Building, Eau Claire, Wis.
- 1903 **Montgomery, Wm. H., M.D.**, Senior Assistant Physician Willard State Hospital, Willard, N. Y. (*Associate.*)
- 1916 **Moody, T. L., M.D.**, Superintendent Dr. Moody's Sanitarium, San Antonio, Tex. (*Associate.*)
- 1912 **Moore, Arthur S., M.D.**, Senior Assistant Physician Middletown State Hospital, Middletown, N. Y. (*Associate.*)
- 1914 **Moore, Joseph W., M.D.**, First Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)

- 1896 Morel, Jules, M. D., Medical Superintendent State Asylum; Commissioner in Lunacy, 56 Boulevard Leopold, Ghent, Belgium. (*Honorary.*)
- 1913 Morris, John N., M. D., Springfield State Hospital, Sykesville, Md. (*Associate.*)
- 1917 Morrison, Angus W., M. D., 406 P. & S., Minneapolis, Minn.
- 1913 Morse, Mary E., M. D., Boston State Hospital, Dorchester Center, Boston, Mass. (*Associate.*)
- 1893 Mosher, J. Montgomery, M. D., 170 Washington Ave., Albany, N. Y.
- 1881 Motet, A. M., M. D., 161 Rue de Charonne, Paris, France. (*Honorary.*)
- 1915 Mullan, E. H., M. D., Surgeon P. H. S., Ellis Island, N. Y.
- 1916 Munnerlyn, J. F., M. D., Assistant Physician Hospital for Insane, Columbia, S. C. (*Associate.*)
- 1886 Munson, James D., M. D., Medical Superintendent Northern Michigan Asylum, Traverse City, Mich.
- 1909 Murdock, J. Morehead, M. D., Superintendent State Institution Feeble-Minded of Western Pennsylvania, Polk, Pa.
- 1912 Myers, Glenn E., M. D., Agnew State Hospital, Agnew, Cal. (*Associate.*)

## N

- 1914 Nairn, B. Ross, M. D., 172 Ashland Ave., Buffalo, N. Y.
- 1896 Neff, Irwin H., M. D., Superintendent Norfolk State Hospital, Pondville, Mass.
- 1913 Neff, Mary Lawson, M. D., Phoenix, Ariz.
- 1914 Neuhaus, George E., M. D., Superintendent Mt. Airy Sanatorium, Denver, Col.
- 1916 Neuman, Theodor W., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1905 Nevin, Ethan A., M. D., Superintendent Custodial Asylum, Newark, N. Y.
- 1915 Newcomb, Philip B., M. D., Pathologist East Louisiana State Hospital for Insane, Jackson, La. (*Associate.*)
- 1900 Nichols, John H., M. D., Resident Physician and Superintendent State Infirmary, Tewksbury, Mass.
- 1913 Nickerson, Mary A., M. D., Rochester State Hospital, Rochester, N. Y. (*Associate.*)
- 1886 Nims, Edward B., M. D. (formerly Superintendent Northampton Insane Hospital), 40 Harvard St., Springfield, Mass.
- 1912 Noble, Ermy C., M. D., Assistant Superintendent Boston State Hospital, Dorchester Center, Mass. (*Associate.*)
- 1912 Noble, Mary E. Gill, M. D., Assistant Physician Boston State Hospital, Dorchester Centre, Mass. (*Associate.*)



- 1903 Norbury, Frank P., M. D., Medical Director, The Norbury Sanatorium, Jacksonville, Ill.
- 1917 Norris, Lester F., M. D., Assistant Superintendent Bangor State Hospital, Bangor, Me. (*Associate.*)
- 1914 North, Emerson A., M. D., Superintendent Longview Hospital, Cincinnati, O.
- 1918 Noyes, Arthur P., M. D., Assistant Physician Psychopathic Hospital, Boston, Mass.

## O

- 1904 O'Brien, John D., M. D., 600 Short Ave., N. W., Canton, O.
- 1913 O'Brien, John F., M. D., Senior Assistant Physician Taunton State Hospital, Taunton, Mass. (*Associate.*)
- 1905 O'Hanlon, George, M. D., Bellevue Hospital, New York, N. Y.
- 1917 O'Hara, Joseph A., M. D., Orleans Hospital for Mental Diseases, New Orleans, La.
- 1912 O'Harrow, Marian, M. D., Assistant Physician Friends' Hospital, Frankford, P. O. Box 20, Station F, Philadelphia, Pa. (*Associate.*)
- 1908 O'Malley, Mary, M. D., Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)
- 1916 O'Meara, Michael J., M. D., Assistant Physician Grafton State Hospital, Worcester, Mass.
- 1889 Orth, H. L., M. D., Harrisburg, Pa.
- 1907 Orton, Samuel T., M. D., Clinical Director and Pathologist Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa.
- 1915 Osnato, Michael, M. D., 270 W. 89th St., New York, N. Y.
- 1898 Ostrander, Herman, M. D., Medical Superintendent Kalamazoo State Hospital, Kalamazoo, Mich.
- 1915 Ostheimer, Alfred J., 2025 Walnut St., Philadelphia, Pa.
- 1917 Otis, Walter J., M. D., 3601 Prytania St., New Orleans, La. (*Associate.*)

## P

- 1916 Pace, Wm. J., M. D., Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)
- 1907 Packard, Frederick H., M. D., Superintendent McLean Hospital, Waverley, Mass. (*Associate.*)
- 1904 Packer, Flavius, M. D., Physician-in-Charge, West Hill, 261st St. and Broadway, New York, N. Y.
- 1889 Page, Charles W., M. D., 94 Woodland St., Hartford, Conn.
- 1894 Page, H. W., M. D., Superintendent Hospital Cottages for Children, Baldwinville, Mass.

- 1912 Paine, Harlan L., M.D., Assistant to Commission Mental Disease, State House, Boston, Mass. (*Associate.*)
- 1887 Paine, N. Emmons, M.D. (formerly Superintendent Westborough State Hospital), The Newton Sanatorium, West Newton, Mass.
- 1918 Palmer, Cora B., M.D., Assistant Physician Northern Hospital for the Insane, Longcliff, Logansport, Ind. (*Associate.*)
- 1914 Palmer, E., M.D., Superintendent Northern Hospital for Insane, Logansport, Ind.
- 1897 Palmer, Harold L., M.D., Utica, N. Y.
- 1894 Parant, A. Victor, M.D., Toulouse, France. (*Honorary.*)
- 1912 Parker, Charles S., M.D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1913 Parker, George M., M.D., St. Vincent's Hospital, New York, N. Y.
- 1905 Parsons, Frederick W., M.D., First Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1909 Partlow, William D., M.D., Assistant Superintendent The Bryce Hospital, Tuscaloosa, Ala.
- 1913 Patterson, Christopher J., M.D., Physician-in-Charge Marshall Sanitarium, Troy, N. Y.
- 1917 Pattrell, Arthur E., M.D., First Assistant Physician Grafton State Hospital, North Grafton, Mass. (*Associate.*)
- 1912 Payne, Florence King, Chittenango, N. Y. (*Associate.*)
- 1912 Payne, Guy, M.D., Medical Superintendent Essex Co. Hospital for Insane, Cedar Grove, N. J.
- 1897 Pease, Caroline S., M.D., Assistant Physician St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
- 1916 Pease, Edmund M., M.D., Assistant Physician Boston State Hospital, Dorchester Center, Mass. (*Associate.*)
- 1917 Peddicord, F. L., M.D., Superintendent Central State Hospital, Lakeland, Ky.
- 1901 Perry, Middleton L., M.D., Superintendent Topeka State Hospital, Topeka, Kans.
- 1893 Peterson, Frederick, M.D., Professor of Psychiatry Columbia University, 20 W. 50th St., New York, N. Y.
- 1912 Peterson, Jessie M., M.D., Chief Resident Physician Department for Women, State Hospital, Norristown, Pa.
- 1912 Pettijohn, Abra C., M.D., Eastern Oklahoma Hospital, Vinita, Okla.
- 1914 Pfeiffer, J. A. F., M.D., 1421 Edmondson Ave., Baltimore, Md. (*Associate.*)
- 1913 Phelps, R. M., M.D., Superintendent St. Peter State Hospital, St. Peter, Minn.
- 1910 Pierson, Clarence, M.D., Superintendent East Louisiana Hospital for Insane, Jackson, La.
- 1914 Pierson, Helena B., M.D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1913 Pierson, Sarah G., M.D., Hudson, N. Y. (*Associate.*)

- 1913 Pietrowicz, Stephen R., M. D., 1152 N. Ashland Ave., Chicago, Ill.  
 1890 Pilgrim, Chas. W., M. D., Chairman State Hospital Commission, Albany, N. Y. (*President, 1911.*)  
 1910 Pitman, Mason W. H., M. D., Riverdale-on-Hudson, New York, N. Y.  
 1914 Podall, H. C., M. D., Assistant Physician State Hospital, Norristown, Pa.  
 1912 Pogue, Mary E., M. D., Wheaton, Ill.  
 1910 Pollock, Henry M., M. D., Superintendent Massachusetts Homeopathic Hospital, Boston, Mass.  
 1905 Porteous, Carlyle A., M. D., Assistant Superintendent Protestant Hospital for the Insane, New P. O. Box 2280, Special Bag, Montreal, Canada.  
 1911 Porter, William C., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)  
 1912 Potter, Clarence A., M. D., Medical Superintendent Gowanda State Hospital, Collins, N. Y. (*Associate.*)  
 1913 Potter, Frederick C., M. D., Pathologist Central Indiana Hospital for Insane, Indianapolis, Ind. (*Associate.*)  
 1913 Powers, Herbert Wm., M. D., Milwaukee Sanitarium, Wauwatosa, Wis.  
 1906 Preston, John, M. D., Superintendent State Lunatic Asylum, Austin, Tex.  
 1915 Price, Susan A., M. D., Farmville, Va. (*Associate.*)  
 1908 Priddy, A. S., M. D., Superintendent Virginia State Epileptic Colony, Madison Heights, Va.  
 1913 Priestman, Gordon, M. D., Assistant Physician, Willard State Hospital, Willard, N. Y. (*Associate.*)  
 1917 Pringle, Cyrus E., M. D., Assistant Physician Buffalo State Hospital, Buffalo, N. Y. (*Associate.*)  
 1914 Pritchard, John A., M. D., Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)  
 1913 Pritchard, William B., M. D., 143 W. 72d St., New York, N. Y.  
 1908 Pritchard, William H., M. D., Superintendent State Hospital, Columbus, O.  
 1898 Prout, Thos. P., M. D., Fair Oaks Sanitarium, Summit, N. J.  
 1912 Purdum, Harry D., M. D., Clinical Director Springfield State Hospital, Sykesville, Md. (*Associate.*)  
 1898 Putnam, Emma, M. D., Poughkeepsie, N. Y.  
 1918 Putney, W. Reid, M. D., Amelia, Va.

## Q

- 1879 Quinby, Hosea M., M. D. (formerly Medical Superintendent Worcester State Hospital), Worcester, Mass.  
 1916 Quinn, F. W., M. D., Assistant Physician Louisiana Hospital for Insane, Pineville, La. (*Associate.*)

## R

- 1918 Raeder, Oscar J., M. D., Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)
- 1910 Ramsey, William E., M. D., Perth Amboy, N. J.
- 1909 Randolph, James H., M. D., St. James Building, Jacksonville, Fla. (*Associate.*)
- 1918 Ranney, Jonathan H., M. D., Assistant Physician Grafton State Hospital, Worcester, Mass. (*Associate.*)
- 1894 Ratliff, J. M., M. D., Medical Superintendent Grandview Sanitarium, Price Hill, Cincinnati, O.
- 1913 Ratliff, Thomas A., M. D., Grandview Sanitarium, Price Hill, Cincinnati, O.
- 1909 Raynor, Mortimer W., M. D., Senior Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1912 Read, Charles F., M. D., Superintendent Chicago State Hospital, Dunning, Ill.
- 1913 Reed, Ralph G., M. D., Assistant Physician State Hospital, Central Islip, N. Y.
- 1918 Reed, Ralph W., M. D., care of Dr. T. E. Reed, Middletown, O.
- 1917 Reeves, Harriet E., M. D., Superintendent Dr. Reeves Nervine, Melrose, Mass.
- 1916 Register, D. W., M. D., Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)
- 1914 Reid, Eva C., M. D., Chief of Psychiatric Clinic, University of California Hospital, San Francisco, Cal. (*Associate.*)
- 1914 Reilly, John A., M. D., Superintendent Southern California State Hospital, Patton, Cal.
- 1915 Reitz, C. B., M. D., Pathologist Homeopathic State Hospital, Allentown, Pa. (*Associate.*)
- 1917 Renner, Dan S., M. D., Assistant Physician Village for Epileptics, Skillman, N. J. (*Associate.*)
- 1911 Rhein, John H. W., M. D., Professor Diseases of Mind and Nervous System, Philadelphia Polyclinic and College of Medicine, 1732 Pine St., Philadelphia, Pa.
- 1916 Riach, Thomas J., M. D., Assistant Physician Kankakee State Hospital, Kankakee, Ill. (*Associate.*)
- 1912 Richards, Cyril G., M. D., Assistant Physician Long Island Hospital, Boston Harbor, Mass. (*Associate.*)
- 1911 Richards, Robert L., M. D., Superintendent Mendocino State Hospital, Talmage, Cal.
- 1904 Richardson, Wm. W., M. D., Medical Director The Mercer Sanitarium, Mercer, Pa.
- 1908 Ricksher, Charles, M. D., Psychopathic Institute, Kankakee, Ill.
- 1913 Ridgway, R. F. L., M. D., First Assistant Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa. (*Associate.*)

- 1902 **Riggs, Charles Eugene, M. D.**, Professor of Nervous and Mental Diseases and Chief of Department Neurology and Psychiatry, University of Minnesota, 10 Crocus Hill, St. Paul, Minn.
- 1911 **Riggs, George Henry, M. D.**, Superintendent Riggs Cottage-Sanitarium, Ijamsville, Md.
- 1917 **Rinde, Hamilton, M. D.**, Assistant Physician Connecticut Hospital for Insane, Middletown, Conn. (*Associate.*)
- 1918 **Ring, Arthur H., M. D.**, Superintendent Ring Sanatorium, Arlington Heights, Mass.
- 1910 **Ripley, Horace G., M. D.**, Assistant Superintendent State Hospital, Taunton, Mass.
- 1916 **Ritchey, R. M., M. D.**, Physician Elgin State Hospital, Elgin, Ill. (*Associate.*)
- 1899 **Ritti, Antoine, M. D.**, Honorary Physician-in-Chief Maison Nationale de Charenton, 68 Boulevard Exelmans, Paris, France. (*Honorary.*)
- 1918 **Roberts, Delparde W., M. D.**, Physician Sacred Heart Sanitarium, Milwaukee, Wis.
- 1901 **Robertson, Frank W., M. D.** (formerly General Superintendent New York State Reformatory at Elmira), 422 West End Ave., New York.
- 1911 **Robinson, G. Wilse, M. D.**, Superintendent The Punton Sanitarium, Kansas City, Mo.
- 1913 **Robinson, Hedley V., M. D.**, 2748 Christopher Columbus St., Montreal, Que. (*Associate.*)
- 1917 **Robinson, Leigh F., M. D.**, Assistant Physician State Hospital, Raleigh, N. C.
- 1909 **Robinson, W. J., M. D.**, Superintendent Asylum for the Insane, London, Ontario.
- 1912 **Rogers, Arthur W., M. D.**, Superintendent Oconomawoc Health Resort for Nervous and Mental Diseases, Oconomawoc, Wis.
- 1907 **Rogers, Chas. B., M. D.**, Senior Assistant Physician, Cincinnati Sanitarium, Cincinnati, O. (*Associate.*)
- 1913 **Rogers, John B., M. D.**, Assistant Physician Napa State Hospital, Napa, Cal. (*Associate.*)
- 1912 **Rooks, J. T., M. D.**, Assistant Physician Kankakee State Hospital, Kankakee, Ill. (*Associate.*)
- 1909 **Rosanoff, A. J., M. D.**, First Assistant Physician Kings Park State Hospital, Kings Park, N. Y.
- 1915 **Rosa, Chas. E., M. D.**, 110 Schweiter Bldg., Wichita, Kans.
- 1907 **Ross, Donald L., M. D.**, Assistant Physician Bloomingdale Hospital, White Plains, N. Y.
- 1912 **Ross, John R., M. D.**, Superintendent Dannemora State Hospital, Dannemora, N. Y. (*Associate.*)
- 1918 **Rowe, Chas. E., M. D.**, Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)

- 1899 Rowe, John T. W., M. D., First Assistant Physician Manhattan State Hospital, Ward's Island, New York, N. Y.
- 1911 Rowe, Melvin J., M. D., First Assistant Physician Mendocino State Hospital, Talmadge, Cal. (*Associate.*)
- 1912 Rowland, George A., M. D., Assistant Physician Columbus State Hospital, Columbus, O. (*Associate.*)
- 1913 Ruggles, Arthur H., M. D., Assistant Physician Butler Hospital, Providence, R. I.
- 1907 Ruland, Frederick D., M. D., Proprietor Dr. Ruland's Sanitarium, Westport, Conn.
- 1912 Runyon, Wm. D., M. D., Sioux City, Iowa. (*Associate.*)
- 1913 Russell, Clarence L., M. D., Assistant Physician Utica State Hospital, Utica, N. Y. (*Associate.*)
- 1912 Russell, Rose A., M. D., Ft. Shaw, Mont. (*Associate.*)
- 1898 Russell, Wm. L., M. D., Superintendent Bloomingdale Hospital, White Plains, N. Y.
- 1907 Ryan, Edward, M. D., Superintendent Rockwood Hospital for the Insane, Kingston, Ontario.
- 1899 Ryon, Walter G., M. D., Superintendent State Hospital, Poughkeepsie, N. Y.

## S

- 1894 Sachs, B., M. D., 116 W. 59th St., New York, N. Y.
- 1912 Salmon, Thomas W., M. D., National Committee for Mental Hygiene, 50 Union Square, New York, N. Y.
- 1915 Sanborn, Chas. F., M. D., Municipal Tuberculosis Sanitarium, Chicago, Ill.
- 1916 Sanders, H. G., M. D., Assistant Physician Western State Hospital, Hopkinsville, Ky. (*Associate.*)
- 1908 Sandy, William C., M. D., Assistant Superintendent State Hospital, Middletown, Conn.
- 1913 Sargent, George F., M. D., Assistant Physician Sheppard and Enoch Pratt Hospital, Towson, Md. (*Associate.*)
- 1913 Saunders, Eleanora B., M. D., York, S. C. (*Associate.*)
- 1915 Sawyer, Carl W., M. D., Sawyer Sanatorium, Marion, Ohio.
- 1909 Scanland, J. M., M. D., Superintendent Montana State Hospital, Warm Springs, Mont.
- 1915 Scheetz, Mildred E., M. D., Senior Assistant Physician St. Elizabeth Hospital, Washington, D. C. (*Associate.*)
- 1909 Schlapp, Max G., M. D., Lecturer on Neuro-Histology and Pathology, Cornell University, 40 E. 41st St., New York City.
- 1914 Schley, R. Montfort, M. D., 267 Elmwood Ave., Buffalo, N. Y.
- 1894 Schmid, H. Ernest, M. D., White Plains, N. Y.
- 1912 Scott, Thompson P., M. D., The Woodson Sanitarium, St. Joseph, Mo. (*Associate.*)
- 1917 Scrutchfield, G. E., M. D., Superintendent State Hospital No. 4, Farmington, Mo.

- 1893 Searcy, James T., M. D., Medical Superintendent The Alabama Insane Hospitals, Tuscaloosa, Ala. (*President, 1913.*)
- 1894 Searl, Wm. A., M. D., Medical Director Fair Oaks Villa, Cuyahoga Falls, Ohio.
- 1889 Sefton, Frederick, M. D., The Pines, Auburn, N. Y.
- 1916 Seiwell, Harry S., M. D., Illinois Soldiers' Home, Quincy, Ill. (*Associate.*)
- 1897 Semelaigne, René, M. D., Medecin en Chef Maison de Santé, Neuilly sur Seine, Paris, France. (*Honorary.*)
- 1892 Semple, John M., M. D., Spokane, Wash.
- 1908 Seybert, Frank T., M. D., Alienist St. Bernard's Hospital, 532 First Ave., Council Bluffs, Iowa.
- 1903 Shanahan, Wm. T., M. D., Medical Superintendent Craig Colony for Epileptics, Sonyea, N. Y.
- 1903 Sharp, Edw. A., M. D., 481 Franklin St., Buffalo, N. Y.
- 1915 Sharp, Geo. A., M. D., Assistant Physician Mattewan State Hospital, Beacon, N. Y. (*Associate.*)
- 1913 Shaw, Arthur L., M. D., Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y.
- 1914 Sheehan, Robert F., M. D., Naval Medical Officer, Washington, D. C. (*Associate.*)
- 1904 Shepherd, Arthur F., M. D., Orchard Springs Sanitarium, Dayton, O.
- 1912 Sherman, Adin, M. D., Superintendent Northern Hospital for Insane, Winnebago, Wis.
- 1905 Shirres, David Alexander, M. D., Consulting Neurologist to the Protestant Hospital for the Insane, 670 W. Sherbrooke St., Montreal, Can.
- 1912 Sights, H. P., M. D., Paducah, Ky.
- 1914 Simon, Theodore W., M. D., Senior Assistant Physician State Hospital, Central Islip, N. Y. (*Associate.*)
- 1892 Simpson, J. C., M. D., 1421 Massachusetts Ave., Washington, D. C.
- 1915 Sims, Haig A., M. D., Clinical Assistant Royal Victoria Hospital, 133 Darocher St., Montreal, Can.
- 1916 Singer, H. Douglas, M. D., Director State Psychopathic Institute, Kankakee, Ill.
- 1910 Skinner, William W., M. D., Consulting Surgeon State Hospital, Willard, N. Y., 449 Main St., Geneva, N. Y.
- 1905 Skoog, A. L., M. D., Associate Professor of Neurology University of Kansas, 1004 Rialto Building, Kansas City, Mo.
- 1918 Slattery, Joseph, M. D., Assistant Physician Massillon State Hospital, Massillon, O. (*Associate.*)
- 1918 Sleyster, Rock, M. D., Medical Superintendent Milwaukee Sanitarium, Drawer D, Wauwatosa, Wis.
- 1904 Slocum, Clarence J., M. D., Craig House, Beacon-on-Hudson, N. Y.
- 1915 Smart, L. Gibbons, M. D., Medical Superintendent Creighton Sanitarium, Lutherville, Md.

- 1915 Smiley, Alton L., M. D., Assistant Physician Colorado Insane Asylum, Pueblo, Colo. (*Associate.*)
- 1885 Smith, Edwin Everett, M. D. (formerly Medical Director New Jersey State Hospital), Kensett, Norwalk, Conn.
- 1898 Smith, Geo. A., M. D., Medical Superintendent Central Islip State Hospital, Central Islip, L. I., N. Y.
- 1902 Smith, Gilbert T., M. D., Mansfield State Training School, Mansfield Depot, Conn. (*Associate.*)
- 1915 Smith, Henry G., M. D., Assistant Physician Essex County Hospital, Cedar Grove, N. J. (*Associate.*)
- 1913 Smith, J. Anson, M. D., Camden County Hospital for Insane, Blackwood, N. J.
- 1913 Smith, J. G. Fowble, M. D., Brunswick, Md. (*Associate.*)
- 1911 Smith, Joseph, M. D., Assistant Physician Long Island State Hospital, Brooklyn, N. Y. (*Associate.*)
- 1912 Smith, Robert P., M. D., Cobb Building, Seattle, Wash.
- 1891 Smith, S. E., M. D., Medical Superintendent Eastern Indiana Hospital for the Insane, "Easthaven," Richmond, Ind. (*President, 1915.*)
- 1885 Smith, Stephen, M. D., 1000 Park Ave., New York, N. Y. (*Honorary.*)
- 1914 Smithson, Wm. W., M. D., Superintendent State Insane Hospital, Asylum, Miss.
- 1917 Smyth, Margaret H., M. D., Assistant Physician State Hospital, Stockton, Cal. (*Associate.*)
- 1911 Snavely, Earl H., M. D., Assistant Physician Essex County Hospital for Insane, Cedar Grove, N. J. (*Associate.*)
- 1908 Solier, Charles H., M. D., Superintendent State Hospital, Evanston, Wyo.
- 1916 Solomon, Harry C., M. D., 32 Robinwood Ave., Jamaica Plain, Boston, Mass. (*Associate.*)
- 1898 Somers, Elbert M., M. D., 33 Lefferts Place, Brooklyn, N. Y.
- 1913 Somerville, William G., M. D., Neurologist City Hospital, Memphis, Tenn.
- 1916 Sommer, Henry J., M. D., Superintendent Blair County Hospital for Insane, Hollidaysburg, Pa.
- 1918 Soper, Arthur E., M. D., Senior Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1907 Southard, Elmer E., M. D., Director Psychopathic Department, Boston State Hospital, 70 Francis Ave., Cambridge, Mass. (*President, 1919.*)
- 1913 Spalding, Harry O., M. D., Superintendent Westborough State Hospital, Westborough, Mass.
- 1915 Spaulding, Edith R., M. D., Stony Brook, Mass. (*Associate.*)
- 1914 Spear, Irving J., M. D., 1810 Madison Ave., Baltimore, Md.



- 1918 Spellman, Dwight S., M. D., Senior Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1899 Spence, James Beveridge, M. D., R. U. I., M. Ch., Resident Physician and Superintendent Staffordshire County Asylum, Burntwood, near Litchfield, England. (*Honorary.*)
- 1894 Sprague, Geo. P., M. D., Superintendent High Oaks Sanitarium, Lexington, Ky.
- 1914 Stack, S. S., M. D., Superintendent Sacred Heart Sanitarium and St. Mary's Hill Hospital, Milwaukee, Wis.
- 1914 Stancell, W. W., M. D., Assistant Physician State Hospital, Raleigh, N. C. (*Associate.*)
- 1892 Stanley, Charles E., M. D., Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)
- 1913 Stearns, Albert Warren, M. D., Billerica, Mass. (*Associate.*)
- 1898 Stearns, Wm. G., M. D., 25 E. Washington St., Chicago, Ill.
- 1914 Steckel, Harry A., M. D., Assistant Physician Kings Park State Hospital, Kings Park, N. Y. (*Associate.*)
- 1884 Stedman, Henry R., M. D., Bournewood Private Hospital for Nervous and Mental Diseases, South St., Brookline, Mass.
- 1895 Stevens, Frank T., M. D., 609 Exchange National Bank Building, Colorado Springs, Colo.
- 1915 Stevenson, W. W., M. D., Assistant Physician Trenton State Hospital, Trenton, N. J. (*Associate.*)
- 1918 Steward, William J., M. D., Physician-in-Chief State Institution for Feeble-Minded, Pennhurst, Pa.
- 1914 Stewart, Robert A., M. D., Assistant Physician Mt. Pleasant State Hospital, Mt. Pleasant, Ia. (*Associate.*)
- 1907 Stick, H. Louis, M. D., Superintendent Hospital Cottages for Children, Baldwinville, Mass.
- 1892 Stone, William A., M. D. (formerly Assistant Superintendent Michigan Asylum for the Insane), 1102 W. Main St., Kalamazoo, Mich.
- 1914 Strecker, Edward A., M. D., Assistant Physician Pennsylvania Hospital, Department for Mental and Nervous Diseases, West Philadelphia, Pa. (*Associate.*)
- 1913 Sturgis, Karl B., M. D., Assistant Physician Maine Insane Hospital, Augusta, Me. (*Associate.*)
- 1912 Sullivan, F. J., M. D., Kankakee State Hospital, Kankakee, Ill. (*Associate.*)
- 1903 Swift, Henry M., M. D., 655 Congress St., Portland, Me.
- 1914 Swift, Walter B., M. D., 110 Bay State Road, Boston, Mass.
- 1918 Swint, Roger C., M. D., Assistant Physician Georgia State Sanitarium, Milledgeville, Ga. (*Associate.*)
- 1894 Sylvester, William E., M. D., Thendara, Canandaigua Lake, N. Y.

## T

- 1899 Taddiken, Paul Gerald, M. D., Superintendent St. Lawrence State Hospital, Ogdensburg, N. Y. (*Associate.*)
- 1915 Taft, Annie E., M. D., 374 Harrison St., Chestnut Hill, Boston, Mass. (*Associate.*)
- 1881 Tamburini, A., M. D., Reggio-Emilia, Italy. (*Honorary.*)
- 1918 Taylor, Francis A., M. D., Assistant Physician Connecticut Hospital for the Insane, Middletown, Conn. (*Associate.*)
- 1914 Taylor, Herbert W., M. D., First Assistant Physician Brattleboro Retreat, Brattleboro, Vt. (*Associate.*)
- 1892 Taylor, Isaac M., M. D., Superintendent Broad Oaks Sanatorium, Morganton, N. C.
- 1915 Taylor, Melvin J., M. D., Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1915 Taylor, Wesley, M. D., Detroit, Mich.
- 1910 Terflinger, Fred. W., M. D., Logansport, Ind.
- 1916 Terhune, Wm. Barclay, M. D., 4516 Perrier St., New Orleans, La.
- 1915 Thom, Douglas A., M. D., National Committee Mental Hygiene, 50 Union St., New York, N. Y. (*Associate.*)
- 1914 Thomas, John N., M. D., Superintendent Louisiana Hospital for Insane, Pineville, La.
- 1906 Thompson, Charles E., M. D., Superintendent Gardner State Colony, Gardner, Mass.
- 1915 Thompson, Chas. W., M. D., Assistant Superintendent Woodcroft, Pueblo, Colo. (*Associate.*)
- 1891 Thompson, J. L., M. D., Assistant Physician State Hospital for the Insane, Columbia, S. C. (*Associate.*)
- 1896 Thompson, Whitefield N., M. D., Medical Superintendent The Hartford Retreat, Hartford, Conn.
- 1914 Thorne, Frederic H., M. D., Pathologist New Jersey State Hospital, Morris Plains, N. J. (*Associate.*)
- 1912 Throckmorton, Tom B., M. D., 922 Equitable Building, Des Moines, Ia.
- 1914 Thurlow, A. A., M. D., First Assistant Physician Oklahoma Hospital for Insane, Norman, Okla. (*Associate.*)
- 1912 Tiffany, William J., M. D., Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)
- 1912 Todd, Leona E., M. D., Woman Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1912 Toomey, Joseph H., M. D., 60 West 70th St., New York City. (*Associate.*)
- 1901 Torney, Geo. H., Jr., M. D., Associate Physician Bournewood Hospital, South St., Brookline, Mass.

- 1902 Toulouse, Edouard, M. D., Physician-in-Chief to Villejuif Asylum; Director Revue de Psychiatrie; Director of Laboratory of Experimental Psychology, l'Ecole des Hautes Etudes, Paris; Villejuif (Seine), France. (*Honorary.*)
- 1899 Townsend, Theodore Irving, M. D., First Assistant Physician Binghamton State Hospital, Binghamton, N. Y.
- 1913 Trader, Wm. N., M. D., Assistant Physician Craig Colony for Epileptics, Sonyea, N. Y. (*Associate.*)
- 1914 Travis, John H., M. D., Senior Assistant Boston State Hospital, Psychopathic Department, Boston, Mass. (*Associate.*)
- 1912 Treadway, Walter L., M. D., Assistant Surgeon U. S. Public Health Service, Washington, D. C.
- 1912 Trenkle, Henry L., M. D., Assistant Physician Sanford Hall, Flushing, N. Y. (*Associate.*)
- 1918 Trent, L. E., M. D., Assistant Physician East Mississippi Insane Hospital, Meridian, Miss. (*Associate.*)
- 1915 Troxell, Geo. Allen, M. D., Assistant Physician Medfield State Hospital, Harding, Mass. (*Associate.*)
- 1914 Trueman, Nelson G., M. D., Assistant Physician Danvers State Hospital, Hathorne, Mass. (*Associate.*)
- 1912 Truitt, R. P., M. D., Snow Hill, Md.
- 1918 Tucker, Beverly R., M. D., 212 West Franklin St., Richmond, Va.
- 1901 Turner, John S., M. D., 806 Southland Life Bldg., Dallas, Tex.
- 1913 Turner, Reeve, M. D., 522 W. 149th St., New York, N. Y.
- 1892 Tuttle, Geo. T., M. D., 535 Beacon St., Boston, Mass.
- 1908 Twohey, John J., M. D., Physician-in-Charge Providence Retreat, Buffalo, N. Y.
- 1909 Tyson, Forrest C., M. D., Superintendent Augusta State Hospital, Augusta, Me.

## U

- 1909 Uhls, L. L., M. D., The Uhls Sanitarium, Overland Park, Kans.
- 1917 Unsworth, Charles V., M. D., 602 Title Guarantee Building, New Orleans, La.

## V

- 1918 Van Cor, Chester A., M. D., Assistant Physician Gardner State Colony, Gardner, Mass. (*Associate.*)
- 1915 Van Nuy, Walter C., M. D., Superintendent Indiana Village for Epileptics, Newcastle, Ind.
- 1911 VanWart, Roy McLean, M. D., Professor Psychiatry Tulane University, 1126 Maison Blanche Building, New Orleans, La.
- 1913 Vaux, Charles L., M. D., Senior Assistant Physician, State Hospital, Central Islip, N. Y. (*Associate.*)
- 1912 Veeder, Willard H., M. D., Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)

- 1893 Voldeng, M. Nelson, M. D., Superintendent The State Hospital and Colony for Epileptics, Woodward, Iowa.
- 1912 Vosburgh, Stephen E., M. D., Assistant Superintendent Maine Insane Hospital, Augusta, Me. (*Associate.*)
- 1918 Vrooman, Fulton S., M. D., Cobourg, Ontario, Can.

## W

- 1895 Wade, J. Percy, M. D., Medical Superintendent Spring Grove State Hospital, Catonsville, Md.
- 1890 Wagner, Charles G., M. D., Medical Superintendent Binghamton State Hospital, Binghamton, N. Y. (*President, 1917.*)
- 1912 Walker, Eloise, M. D., University Health Service, Ann Arbor, Mich. (*Associate.*)
- 1905 Walker, Irving Lee, M. D., Assistant Physician Rochester State Hospital, Rochester, N. Y. (*Associate.*)
- 1905 Walker, Lewis M., M. D., Assistant Physician Pennsylvania Hospital, Department for Nervous and Mental Diseases, West Philadelphia, Pa.
- 1914 Walker, N. P., M. D., Assistant Physician Georgia State Sanitarium, Milledgeville, Ga. (*Associate.*)
- 1916 Walker, W. K., M. D., St. Francis Hospital, Pittsburgh, Pa.
- 1918 Walsh, James J., M. D., 309 So. Aberdeen St., Chicago, Ill. (*Associate.*)
- 1917 Walsh, Wm. S., M. D., Assistant Physician Maine School for Feeble-Minded, West Pownal, Me. (*Associate.*)
- 1913 Wardner, Drew M., M. D., 571 Park Ave., New York, N. Y. (*Associate.*)
- 1912 Waterman, Chester, M. D., Assistant Physician Manhattan State Hospital, Ward's Island, N. Y. (*Associate.*)
- 1914 Waterman, Paul, M. D., 1 Fern Ave., Hartford, Conn.
- 1916 Waters, Pearl S., M. D., Assistant Physician Fergus Falls State Hospital, Fergus Falls, Minn.
- 1913 Webster, B. R., M. D., Assistant Physician Matteawan State Hospital, Beacon, N. Y. (*Associate.*)
- 1910 Weeks, David F., M. D., Medical Superintendent and Executive Officer New Jersey State Village for Epileptics, Skillman, N. J.
- 1913 Weisenburg, T. H., M. D., 2030 Chestnut St., Philadelphia, Pa.
- 1893 Welch, G. O., M. D., Medical Superintendent Fergus Falls State Hospital, Fergus Falls, Minn.
- 1916 Wellington, Anna C., M. D., Assistant Physician Psychopathic Hospital, Boston, Mass. (*Associate.*)
- 1915 Wenn, J. F., M. D., Resident Physician St. Mary's Hill, Milwaukee, Wis.
- 1892 Wentworth, Lowell F., M. D., Assistant Director Commission on Mental Diseases, 36 State House, Boston, Mass.

- 1914 Wescott, Adeline M., M. D., St. Luke's Hospital, Newburgh, N. Y.
- 1904 West, Calvin B., M. D., Senior Assistant Physician Hudson River State Hospital, Poughkeepsie, N. Y. (*Associate.*)
- 1916 West Carl A., M. D., Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)
- 1912 Weston, Paul G., M. D., Pathologist State Hospital, Warren, Pa. (*Associate.*)
- 1912 White, F. S., M. D., Terrell, Tex.
- 1906 White, Grace E., M. D., Wood Lea Sanitarium, 300 Ardmore Ave., Ardmore, Pa. (*Associate.*)
- 1902 White, Wm. A., M. D., Superintendent St. Elizabeth Hospital, Washington, D. C.
- 1916 White, Wm. B., M. D., Assistant Physician Dixmont State Hospital, Dixmont, Pa. (*Associate.*)
- 1912 Whitney, Ray L., M. D., Assistant Physician McLean Hospital, Waverley, Mass. (*Associate.*)
- 1916 Whitten, Benjamin O., M. D., Assistant Physician State Hospital, Columbia, S. C. (*Associate.*)
- 1914 Wholey, Cornelius C., M. D., 1018 Westinghouse Bldg., Pittsburgh, Pa.
- 1915 Wickens, Mary, M. D., Woman Physician Eastern Indiana Hospital, Richmond, Ind. (*Associate.*)
- 1898 Wilgus, Sidney D., M. D., Superintendent and Proprietor The Ransom Sanitarium, Box 304, Rockford, Ill.
- 1913 Williams, B. F., M. D., Lincoln, Nebr.
- 1906 Williams, Berthold A., M. D., 5 W. 8th St., Cincinnati, O.
- 1916 Williams, C. F., M. D., Superintendent State Hospital for Insane, Columbia, S. C.
- 1916 Williams, Frankwood E., M. D., Associate Medical Director National Committee for Mental Hygiene, 50 Union Sq., New York, N. Y.
- 1904 Williams, G. H., M. D., Assistant Physician Cleveland State Hospital, Cleveland, O.
- 1918 Williams, Rodney R., M. D., Senior Assistant Physician Binghamton State Hospital, Binghamton, N. Y. (*Associate.*)
- 1910 Williams, Tom A., M. D., 1705 W St., N. W., Washington, D. C.
- 1884 Williamson, Alonzo P., M. D., 842 N. 2d St., Santa Monica, Cal.
- 1888 Wilsey, O. J., M. D., Physician-in-Charge Long Island Home, Amityville, N. Y.
- 1914 Wilson, Anita A., M. D., Assistant Physician St. Elizabeth's Hospital, Washington, D. C. (*Associate.*)
- 1910 Wilson, William T., M. D., Superintendent Hospital for the Insane, Penetanguishene, Ont.
- 1907 Winterode, Robert P., M. D., Superintendent Crownsville State Hospital, Crownsville, Md.
- 1912 Wiseman, John I., M. D., Lieut. M. R. C., U. S. Army. (*Associate.*)
- 1895 Witte, M. E., M. D., Medical Superintendent Clarinda State Hospital, Clarinda, Ia.
- 1902 Wolfe, Mary Moore, M. D., 29 S. 3d St., Lewisburg, Pa.

- 1910 Woodbury, Frank, M. D., Secretary Committee on Lunacy State of Pennsylvania, 717 Bulletin Building, Philadelphia, Pa.
- 1907 Woodman, Robert C., M. D., First Assistant Physician Middletown State Homeopathic Hospital, Middletown, N. Y. (*Associate.*)
- 1890 Woodson, C. R., M. D., Dr. C. R. Woodson's Sanitarium, St. Joseph, Mo.
- 1911 Woodward, Esther S. B., M. D., Psychopathic Hospital, Boston, Mass.
- 1918 Woodward, Samuel B., M. D., Worcester, Mass.
- 1901 Work, Hubert, M. D., Superintendent Woodcroft Hospital for Nervous Diseases, Pueblo, Col. (*President, 1912.*)
- 1916 Work, Philip, M. D., Associate Medical Superintendent, Woodcroft Hospital, Pueblo, Colo. (*Associate.*)
- 1915 Wright, Harold W., M. D., Physicians' Bldg., San Francisco, Cal.
- 1893 Wright, W. E., M. D., 204-206 State St., Harrisburg, Pa. (*Associate.*)
- 1912 Wright, Wm. W., M. D., Psychiatric Institute, Ward's Island, New York, N. Y. (*Associate.*)
- 1918 Wylie, A. R. T., M. D., Superintendent North Dakota Institution for Feeble-Minded, Grafton, N. D.

## Y

- 1912 Yarbrough, Y. H., M. D., Assistant Physician Georgia State Sanitarium, Milledgeville, Ga. (*Associate.*)
- 1894 Yellowlees, David, M. D., L. R. C. S., Edin., F. F. P. S. and LL. D., Glasgow (formerly Physician Superintendent Glasgow Royal Asylum, Gartnavel), 6 Albert Gate, Dowanhill, Glasgow, Scotland. (*Honorary.*)
- 1917 Young, A. F., M. D., Superintendent Milwaukee Hospital for Insane, Milwaukee, Wis.
- 1916 Young, Annie Austin, Anderson, S. C. (*Associate.*)
- 1917 Young, Beverly, M. D., Superintendent Southwestern Insane Asylum, San Antonio, Tex.
- 1906 Young, David, M. D. (formerly Superintendent Asylum for the Insane, Selkirk, Manitoba, Canada), 494 Camden Place, Winnipeg, Manitoba, Canada.
- 1915 Young, Ernest H., M. D., Assistant Superintendent Rockwood Hospital, Kingston, Ontario, Can.
- 1914 Young, Hugh Hampton, M. D., President State Lunacy Commission of Maryland, 330 N. Charles St., Baltimore, Md. (*Honorary.*)
- 1906 Youngling, George S., M. D., Consulting Physician Central Islip State Hospital, 453 W. 34th St., New York, N. Y.
- 1913 Yule, Lorne W., M. D., Assistant Physician State Hospital, Cleveland, O.

## LIFE MEMBERS

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- 1872 Theodore H. Kellogg, M. D., New York, N. Y.
- 1874 Carlos F. MacDonald, M. D., New York, N. Y.
- 1879 Hosea M. Quinby, M. D., Worcester, Mass.
- 1879 Henry M. Hurd, M. D., Baltimore, Md.
- 1880 Walter Channing, M. D., Brookline, Mass.
- 1881 Edward Cowles, M. D., Plymouth, Mass.
- 1881 Richard Dewey, M. D., Wauwatosa, Wis.
- 1882 Shailer E. Lawton, M. D., Brattleboro, Vt.
- 1882 Samuel B. Lyon, M. D., White Plains, N. Y.
- 1883 Gershom H. Hill, M. D., Des Moines, Ia.
- 1883 Charles G. Hill, M. D., Baltimore, Md.
- 1883 Robert H. Chase, M. D., Philadelphia, Pa.
- 1883 Sanger Brown, M. D., Kenilworth, Ill.
- 1883 Charles P. Bancroft, M. D., Concord, N. H.
- 1884 Henry R. Stedman, M. D., Brookline, Mass.
- 1884 Alonzo P. Williamson, M. D., Santa Monica, Cal.
- 1885 Edwin E. Smith, M. D., Norwalk, Conn.
- 1885 Charles K. Clark, M. D., Toronto, Can.
- 1885 Michael Campbell, M. D., Bearden, Tenn.
- 1885 Henry A. Hutchinson, M. D., Dixmont, Pa.
- 1886 G. Alder Blumer, M. D., Providence, R. I.
- 1886 Wm. D. Granger, M. D., Bronxville, N. Y.
- 1886 L. S. Hinckley, M. D., Newark, N. J.
- 1886 James D. Munson, M. D., Traverse City, Mich.
- 1886 Edward B. Nims, M. D., Springfield, Mass.
- 1887 N. Emmons Paine, M. D., West Newton, Mass.
- 1888 Daniel A. Harrison, M. D., Whitestone, L. I.
- 1888 Eugene H. Howard, M. D., Rochester, N. Y.
- 1888 O. J. Wilsey, M. D., Amityville, N. Y.
- 1889 H. L. Orth, M. D., Harrisburg, Pa.
- 1889 Chas. W. Page, M. D., Hartford, Conn.
- 1889 Frederick Sefton, M. D., Auburn, N. Y.

## HONORARY MEMBERS

- 1890 Henry M. Bannister, M. D., Evanston, Ill.  
 1898 James M. Buckley, D. D., LL. D., Morristown, N. J.  
 1908 Shepherd I. Franz, A. B., Ph. D., Washington, D. C.  
 1891 G. Stanley Hall, Ph. D., LL. D., Worcester, Mass.  
 1899 Henry Hun, M. D., Albany, N. Y.  
 1896 Jules Morel, M. D., Mons, Belgium.  
 1881 A. Motet, M. D., Paris, France.  
 1894 A. Victor Parant, M. D., Toulouse, France.  
 1899 Antoine Ritti, M. D., Charenton, près Paris, France.  
 1897 René Semelaigne, M. D., Paris, France.  
 1885 Stephen Smith, M. D., New York, N. Y.  
 1899 James Beveridge Spence, M. D., M. C. Q. U. I., Burntwood, England.  
 1881 A. Tamburini, M. D., Reggio-Emilia, Italy.  
 1902 Edouard Toulouse, M. D., Villejuif, France.  
 1894 David Yellowlees, M. D., F. R. F. P. and S., LL. D., Glasgow, Scotland.  
 1914 Hugh Hampton Young, M. D., Baltimore, Md.

### Total Membership:

Active .....	508
Associate .....	355
Life .....	32
Honorary .....	16

Total ..... 911

The following tabulation shows the membership of the Association for the past decade:

Members	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919
Active.....	339	337	360	398	457	457	465	475	486	508
Associate.....	134	134	133	203	250	289	323	342	368	355
Life.....						17	21	27	30	32
Honorary.....	24	22	21	20	19	19	18	18	17	16
Total.....	497	493	514	621	726	782	827	862	901	911

NOTE.—It will be observed that the list of members as here printed shows the date when each member became identified with the Association. This arrangement is believed to be a valuable addition to the list which will be appreciated.



## NECROLOGY

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- Wesley Mills, M. D., Montreal, Que. Died February 13, 1915.  
 Henry S. Noble, M. D., Middletown, Conn. Died March 16, 1915.  
 Albert R. Moulton, M. D., Philadelphia, Pa. Died August 16, 1915.  
 John M. Bemis, M. D., Worcester, Mass. Died September 22, 1915.  
 Austin Flint, M. D., New York, N. Y. Died September 22, 1915.  
 Wm. Noyes, M. D., Jamaica Plains, Mass. Died October 20, 1915.  
 Alfred I. Noble, M. D., Kalamazoo, Mich. Died January 20, 1916.  
 R. W. Bruce Smith, M. D., Toronto, Canada.  
 C. F. Gilliam, M. D., Columbus O. Died April 12, 1916.  
 George H. Schwinn, M. D., Washington, D. C. Died February 6, 1916.  
 R. F. Parsons, M. D., Mt. Holly, N. J. Died November 11, 1916.  
 Victor A. Bles, M. D., Elgin, Ill. Died May 9, 1916.  
 Charles H. Hughes, M. D., St. Louis, Mo. Died July 13, 1916.  
 C. Von A. Schneider, M. D., Collins, N. Y. Died January 28, 1917.  
 George Stockton, M. D., Columbus, O. Died January 9, 1917.  
 Wm. Mabon, M. D., New York, N. Y. Died February 9, 1917.  
 Elliott Gorton, M. D., Summit, N. J. Died March 3, 1917.  
 Moses J. White, M. D., Wauwatosa, Wis. Died March 14, 1917.  
 Edward P. Frost, M. D., Boston, Mass. Died May 23, 1917.  
 G. H. Moody, M. D., San Antonio, Tex. Died April 29, 1917.  
 Alexander R. Urquhart, M. D. (Honorary), Perth, Scotland. Died July 31,  
 1917.  
 Charles H. North, M. D., Dannemora, N. Y. Died December 12, 1917.  
 John B. Chapin, M. D., Canandaigua, N. Y. Died January 17, 1918.  
 George Villeneuve, M. D., Montreal, Que. Died January 21, 1918.  
 Thomas C. Biddle, M. D., Topeka, Kans. Died February 16, 1918.  
 Wm. Austin Macy, M. D., Kings Park, N. Y. Died May 21, 1918.  
 Ernest V. Scribner, M. D., Worcester, Mass. Died June 14, 1918.  
 Frederick L. Hills, M. D., Bangor, Me. Died July 20, 1918.  
 George W. Gorrill, M. D., Buffalo, N. Y. Died October 22, 1918.  
 Arthur K. Petery, M. D., Norristown, Pa. Died October 2, 1918.  
 Edgar H. Wiswall, M. D., Wellesley, Mass. Died October 7, 1918.  
 Flora E. P. Easton, M. D., Norristown, Pa. Died October 25, 1918.  
 Morris J. Karpas, M. D., New York, N. Y. Died ———.  
 Alfred Glascock, M. D., Washington, D. C. Died October 10, 1918.  
 Capt. James F. Munson, M. D., Sonyea, N. Y. Died October 25, 1918.  
 George B. Wolff, M. D., Baltimore, Md. Died December 21, 1918.  
 Emmanuel Régia, M. D. (Honorary), Bordeaux, France. Died January —,  
 1918.  
 George F. Harris, M. D., Buffalo, N. Y. Died March 18, 1918.  
 Pearl T. Haskell, M. D., Bangor, Me. Died April 13, 1919.

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John H. Callender, M. D., Nashville, Tenn.....	1882-1883
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Eugene Grissom, M. D., Raleigh, N. C.....	1887-1888
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Charles G. Wagner, M. D., Binghamton, N. Y.....	1916-1917
James V. Anglin, M. D., St. John, N. B.....	1917-1918
Ernest E. Southard, M. D., Boston, Mass.....	1918-1919

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<b>Henry C. Eyman, M. D., Massillon, Ohio.....</b>	<b>1915-1918</b>
<b>H. W. Mitchell, M. D., Warren, Pa.....</b>	<b>1918-</b>

# MEETING PLACES OF ASSOCIATION OF MEDICAL SUPERINTENDENTS OF AMERICAN IN- STITUTIONS FOR THE INSANE

1st	1844	Philadelphia, Pa., Jones Hotel, Oct. 16, 1844.	37th	1883	Newport, R. I.
		Pres., Dr. Samuel B. Woodward.	38th	1884	Philadelphia, Pa.
		Vice-Pres., Dr. Samuel White.	39th	1885	Saratoga, N. Y.
		Sec.-Treas., Dr. Thomas S. Kirkbride.	40th	1886	Lexington, Ky.
	1845	No meeting held.	41st	1887	Detroit, Mich.
2d	1846	Washington, D. C.	42d	1888	Fortress Monroe, Va.
	1847	No meeting held.	43d	1889	Newport, R. I.
3d	1848	New York, N. Y.	44th	1890	Niagara Falls, N. Y.
4th	1849	Utica, N. Y.	45th	1891	Washington, D. C.
5th	1850	Boston, Mass.	46th	1892	Washington, D. C.
6th	1851	Philadelphia, Pa.			New constitution adopted.
7th	1852	New York, N. Y.			Name changed to American Medico-Psychological Ass'n.
8th	1853	Baltimore, Md.	47th	1893	Chicago, Ill.
9th	1854	Washington, D. C.	50th	1894	Philadelphia, Pa.
10th	1855	Boston, Mass.			Fiftieth year since foundation.
11th	1856	Cincinnati, Ohio.			Semi-centennial.
12th	1857	New York, N. Y.			Number of meetings changed.
13th	1858	Quebec, Que.			Proceedings published in separate volume.
14th	1859	Lexington, Ky.	51st	1895	Denver, Col.
15th	1860	Philadelphia, Pa.	52d	1896	Boston, Mass.
	1861	No meeting held on account of the disturbed condition of the country.	53d	1897	Baltimore, Md.
16th	1862	Providence, R. I.	54th	1898	St. Louis, Mo.
17th	1863	New York, N. Y.	55th	1899	New York, N. Y.
18th	1864	Washington, D. C.	56th	1900	Richmond, Va.
19th	1865	Pittsburgh, Pa.	57th	1901	Milwaukee, Wis.
20th	1866	Washington, D. C.	58th	1902	Montreal, Que.
21st	1867	Philadelphia, Pa.	59th	1903	Washington, D. C.
22d	1868	Boston, Mass.	60th	1904	St. Louis, Mo.
23d	1869	Staunton, Va.	61st	1905	San Antonio, Tex.
24th	1870	Hartford, Conn.	62d	1906	Boston, Mass.
25th	1871	Toronto, Ont.	63d	1907	Washington, D. C.
26th	1872	Madison, Wis.	64th	1908	Cincinnati, Ohio.
27th	1873	Baltimore, Md.	65th	1909	Atlantic City, N. J.
28th	1874	Nashville, Tenn.	66th	1910	Washington, D. C.
29th	1875	Auburn, N. Y.	67th	1911	Denver, Col.
30th	1876	Philadelphia, Pa.	68th	1912	Atlantic City, N. J.
31st	1877	St. Louis, Mo.	69th	1913	Niagara Falls, Ont.
32d	1878	Washington, D. C.	70th	1914	Baltimore, Md.
33d	1879	Providence, R. I.	71st	1915	Fortress Monroe, Va.
34th	1880	Philadelphia, Pa.	72d	1916	New Orleans, La.
35th	1881	Toronto, Ont.	73d	1917	New York, N. Y.
36th	1882	Cincinnati, Ohio.	74th	1918	Chicago, Ill.
			75th	1919	Philadelphia, Pa.

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Melvin J. Taylor, M. D., Assistant Physician.

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James P. Kelleher, M. D., Senior Assistant Physician.

Dwight S. Spellman, M. D., Senior Assistant Physician.

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George T. Harding, M. D., Columbus.

A. B. Howard, M. D., Cleveland.

Robert Ingram, M. D., Cincinnati.

J. M. Lewis, M. D., Cleveland.

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## P

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**NORTHERN HOSPITAL FOR THE INSANE, WINNEBAGO.**

Adin Sherman, M. D., Superintendent.

**OAK LEIGH SANITARIUM, LAKE GENEVA.**

No members.

**OCONOMAWOC HEALTH RESORT, OCONOMAWOC.**

Arthur W. Rogers, M. D., Superintendent.

**PALMYRA SANITARIUM, PALMYRA.**

No members.

**SACRED HEART SANITARIUM, MILWAUKEE, WIS.**

Delparde W. Roberts, M. D., Physician.

**THE SANATORIUM, HUDSON.**

No members.

**WAUKESHA SPRINGS SANITARIUM, WAUKESHA.**

Byron M. Caples, M. D., Superintendent.

W. W. Eichelberger, M. D., Assistant Physician.

**WISCONSIN HOME FOR FEEBLE-MINDED, CHIPPEWA FALLS.**

No members.

**WISCONSIN STATE HOSPITAL FOR CRIMINAL INSANE, WAUPUN.**

No members.

**WISCONSIN STATE HOSPITAL FOR THE INSANE, MENDOTA.**

William F. Lorenz, M. D., Director Psychiatric Institute

William F. Becker, M. D., Milwaukee.

Anne Burnet, M. D., Antigo.

John B. Edwards, M. D., Milwaukee.

Roy E. Mitchell, M. D., Eau Claire.

S. S. Stack, M. D., Milwaukee.

J. F. Wenn, M. D., Milwaukee.

M. J. White, M. D., Milwaukee.

**WYOMING—STATE HOSPITAL FOR THE INSANE, EVANSTON.**

Charles H. Solter, M. D., Superintendent.

**BRITISH AMERICA.****BRITISH COLUMBIA—PUBLIC HOSPITAL FOR INSANE, NEW WESTMINSTER**

Charles Edward Doherty, M. D., Superintendent.

James G. McKay, M. D., New Westminster.

**MANITOBA—ASYLUM FOR THE INSANE, SELKIRK.**

No members.

**BRANDON ASYLUM, BRANDON.****H. E. Hicks, M. D., Assistant Physician.**

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**David Young, M. D., Winnipeg.****NEW BRUNSWICK—THE PROVINCIAL HOSPITAL, ST. JOHN.****James V. Anglin, M. D., Superintendent.****NEWFOUNDLAND—ASYLUM FOR THE INSANE, ST. JOHN'S.**

No members.

**NOVA SCOTIA—NOVA SCOTIA HOSPITAL, HALIFAX.****Frederick E. Lawlor, M. D., Superintendent.**

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**W. H. Hattie, M. D., Halifax.****ONTARIO—ASYLUM FOR THE INSANE, COBOURG.**

No members.

**ASYLUM FOR THE INSANE, LONDON.****W. J. Robinson, M. D., Superintendent.****ASYLUM FOR THE INSANE, PENETANGUISHENE.****William T. Wilson, M. D., Superintendent.****HOMEWOOD SANITARIUM, GUELPH.****Alfred T. Hobbs, M. D., Superintendent.****E. C. Barnes, M. D., Assistant Physician.****HOSPITAL FOR THE INSANE, BROCKVILLE.****John C. Mitchell, M. D., Superintendent.****HOSPITAL FOR THE INSANE, HAMILTON.****W. M. English, M. D., Superintendent.****Peter MacNaughton, M. D., Assistant Superintendent.****HOSPITAL FOR THE INSANE, TORONTO.****James M. Forster, M. D., Superintendent.****Harvey Clare, M. D., Assistant Superintendent.****MIMICO HOSPITAL FOR THE INSANE, TORONTO.****Nelson H. Beemer, M. D., Superintendent.****ROCKWOOD HOSPITAL FOR THE INSANE, KINGSTON.****Edward Ryan, M. D., Superintendent.****Ernest H. Young, M. D., Assistant Superintendent.****SIMCOE HALL, BARRIE.****W. C. Barber, M. D., Superintendent.****TORONTO GENERAL HOSPITAL, TORONTO.**

No members.

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**Chas. K. Clarke, M. D., Toronto.****Jno. G. Fitzgerald, M. D., Toronto.****Fulton S. Vrooman, M. D., Cobourg.**

**PRINCE EDWARD ISLAND—FALCONWOOD HOSPITAL FOR INSANE, CHARLOTTETOWN.**

No members.

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V. L. Goodwill, M. D., Charlottetown.

**QUEBEC—BEAUPORT ASYLUM FOR THE INSANE, BEAUPORT, QUEBEC.**

M. D. Brochu, M. D., Superintendent.

**PROTESTANT HOSPITAL FOR THE INSANE, MONTREAL.**

T. J. W. Burgess, M. D., Superintendent.

Carlyle A. Porteous, M. D., Assistant Superintendent.

Andrew Macphail, M. D., Consulting Pathologist.

David Alexander Shirres, M. D., Consulting Neurologist.

Robt. C. Hiscock, M. D., Assistant Physician.

J. F. Leigh Brown, M. D., Assistant Physician.

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E. Philippe Chagnon, M. D., Montreal.

Hedley V. Robinson, M. D., Montreal.

Haig A. Sims, M. D., Montreal.

**SAINT JEAN DE DIEU HOSPITAL, MONTREAL.**

Francis E. Devlin, M. D., Superintendent.

**SASKATCHEWAN.**

James W. McNeill, M. D., Battleford.

**CUBA—MALBERTI'S SANITARIUM, HAVANA.**

José A. Malberti, M. D., Physician-in-Charge.

**HAWAII.**

Wm. A. Boyd, M. D., Schofield Barracks.

**PORTO RICO—INSANE ASYLUM, SAN JUAN.**

No members.

**PHILIPPINE ISLANDS.**

A. P. Goff, M. D., Manila.

# AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

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## CONSTITUTION.

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### ARTICLE I.

This organization shall be known as the AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION, this name being adopted in 1892 by "The Association of Medical Superintendents of American Institutions for the Insane," founded in 1844.

### ARTICLE II.

The object of this Association shall be the study of all subjects pertaining to mental disease, including the care, treatment, and promotion of the best interests of the insane.

### ARTICLE III.

There shall be five classes of members: (1) Active members, who shall be physicians, resident in the United States and British America, especially interested in the treatment of insanity; (2) Associate members; (3) Life members; (4) Honorary members; and (5) Corresponding members.

### ARTICLE IV.

The officers of the Association shall consist of a President, Vice-President, Secretary—who shall also be the Treasurer—three Auditors, and twelve other members of the Association to be called Councilors; all of these officers together shall constitute a body which shall be known as the Council.

NOTE.—The Association of Medical Superintendents of American Institutions for the Insane was founded in 1844 by the original thirteen members. In 1891, when its membership had increased to more than two hundred, it was proposed, at the annual meeting of that year in Washington, to form a better organization of the Association—its work having previously been done under the somewhat unstable rules of custom and a few resolutions scattered through its records. The proposition was agreed to, and at the annual meeting in Washington, in 1892, there were unanimously adopted the following Constitution and By-Laws, with the change of name to the AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

## ARTICLE V.

The Active members of the Association shall include all past and present medical superintendents named in the official list published for 1892 of members of "The Association of Medical Superintendents of American Institutions for the Insane"; the Life members shall be such Active members as shall have been members of the Association for a consecutive period of thirty (30) years; the Honorary members shall include those so designated in that list; the Associate members shall include all the assistant physicians named in the same list; it being provided that said list shall be corrected by the Council, as may be necessary to carry out the intention of the Constitution as to the continuance of existing membership.

Every candidate for admission to the Association hereafter as an Active member shall be proposed to the Council, in writing, in an application addressed to the President, at any annual meeting preceding the one at which the election is held. Honorary, Associate, or Corresponding members shall be proposed to the Council, in writing, in an application addressed to the President, at least two months prior to the meeting of the Association. Every application of whatever class must include a statement of the candidate's name and residence, professional qualifications, and any appointments then or formerly held, and certifying that he is a fit and proper person for membership. In the case of a candidate for Active or Associate membership, the application shall be signed by three Active members of the Association; and by six Active members for the proposal of an Honorary or Corresponding member. The names of all candidates approved by a majority vote of members of the Council present at its annual meeting shall be presented on a written or printed ballot to the Association at its concurrent annual meeting, at least one session previous to that at which the election is made, which shall be by ballot at a regular session, and require a majority vote of the members present. Physicians who, by their professional work or published writings, have shown a special interest in the care and welfare of the insane, are eligible to Active membership. The only persons eligible for Associate membership are regularly appointed assistant physicians of institutions for the insane that are regarded to be properly such by the Council; and they are

eligible for such membership only during the time they are holding such appointments. After holding such an appointment three years, an Associate member may become an Active member by making application, in writing, to the Council, and upon its approval, being elected in the manner heretofore prescribed.

#### ARTICLE VI.

Physicians and others who have distinguished themselves by their attainments in branches of science connected with insanity, or who have rendered signal service in philanthropic efforts to promote the interests of the insane, shall be eligible for Honorary membership.

Physicians not residents in the United States and British America, who are actively engaged in the treatment of insanity, may be elected Corresponding members.

Active members only shall be entitled to a vote at any meeting, or be eligible to any office. Life, Honorary and Corresponding members shall be exempt from all payments of annual dues to the Association.

#### ARTICLE VII.

Any member of the Association may withdraw from it on signifying his desire to do so in writing to the Secretary: *Provided*, That he shall have paid all his dues to the Association. Any member who shall fail for three successive years to pay his dues after special notice by the Treasurer shall be regarded as having resigned his membership, unless such dues shall have been remitted by the Council for good and sufficient reasons.

Any member who shall be declared unfit for membership by a two-thirds vote of the members of the Council present at an annual meeting of that body shall have his name presented by it for the action of the Association from which he shall be dismissed if it be so voted by two-thirds of the members present at its annual meeting.

#### ARTICLE VIII.

The Officers and Councilors shall be elected at each annual meeting. They shall be nominated to the Association on the second day of the annual meeting in the order of business of the first session of that day, by a committee appointed for that pur-



pose by the President; and the election shall take place immediately. The election shall be made as the meeting may determine, and the person who shall have received the highest number of votes shall be declared elected to the office for which he has been nominated.

The President, Vice-President, the Secretary and Treasurer, and Auditors shall hold office for one year or until the beginning of the term for which their successors are elected. One Auditor shall be elected for one year, one for two years, and one for three years. The Secretary and Treasurer and one Auditor are eligible for re-election. At the first election of Councilors, four members shall be elected for one year, four for two years, and four for three years; and thereafter four members shall be elected each year to hold office three years, or until their successors are elected. The President, Vice-President, one Auditor, and the four retiring Councilors are ineligible for re-election to their respective offices for one year immediately following their retirement. All the officers and Councilors shall enter upon their duties immediately after their election, excepting the President and Vice-President. When any vacancies occur in any of the offices of the Association, they shall be filled by the Council until the next annual meeting.

A quorum of the Council shall be formed by six members; and of the Association by twenty Active members.

#### ARTICLE IX.

The President and Vice-President for the year shall enter on their duties at the close of the business of the annual meeting at which they are elected. The President shall prepare an inaugural address to be delivered at the opening session of the meeting. He shall preside at all the annual or special meetings of the Association or Council, or in his absence at any time, the Vice-President shall act in his place.

The Secretary and Treasurer shall keep the records of the Association and perform all the duties usually pertaining to that office, and such other duties as may be prescribed for him by the Council; and under the same authority he shall receive and disburse and duly account for all sums of money belonging to the Association. He shall keep accurate accounts and vouchers of all his receipts and payments on behalf of the Association, and of

all invested funds, with the income and disposition thereof, that may be placed in his keeping, and shall submit these accounts, with a financial report for the preceding year, to the Council at its annual meeting. Each annual statement shall be examined by the Auditors, who shall prepare and present at each annual meeting of the Association a report showing its financial condition. The Council shall have charge of any funds in the possession of the Association, and which shall be invested under its direction and control. The Council shall keep a careful record of its proceedings, and make an annual report to the Association of matters of general interest. The Council shall also print annually the proceedings of the meetings of the Association and the reports of the Treasurer and Auditors.

The Council is empowered to manage all the affairs of the Association, subject to the Constitution and By-Laws; to appoint committees from the membership of the Association, and spend money out of its surplus funds for special scientific investigations in matters pertaining to the objects of the Association, to publish reports of such scientific investigations; to apply the income of special funds, at its discretion, to the purposes for which they were intended. The Council may also engage in the regular publication of reports, papers, transactions, and other matters, in annual volume, or in a journal, in such manner and at such times as the Council may determine, with the approval of the Association.

#### ARTICLE X.

Amendments to the Constitution and By-Laws shall be taken up for consideration at the first session of the second day of any annual meeting, and may be made by a two-thirds vote of all the members present: *Provided*, That notice of such proposed amendments be given in writing at the annual meeting next preceding. It shall be the duty of the Secretary to send to all the members a copy of any proposed amendment at least three months previous to the meeting when the action is to be taken.

## BY-LAWS.

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ARTICLE I.

The meetings of the Association shall be held annually. The time and place of each meeting shall be named by the Council, and reported to the Association for its action at the preceding meeting. Each annual meeting shall be called by printed announcements sent to each member at least three months previous to the meeting.

The Council shall hold an annual meeting concurrent with the annual meeting of the Association; and the Council shall hold as many sessions and at such times as the business of the Association may require.

Special meetings of the Council may be called by the order of the Council. The President shall have authority at any time, at his own discretion, to instruct the Secretary to call a special meeting of the Council; and he shall be required to do so upon a request signed by six members of the Council. Such special meetings shall be called by giving at least four weeks' written notice.

## ARTICLE II.

Each and every Active and Associate member shall pay an annual tax to the Treasurer, the amount to be fixed annually by the Council, not to exceed five dollars for an Active member, or two dollars for an Associate member.

## ARTICLE III.

The order of business of each annual meeting of the Association shall be determined by the Council, and shall be printed for the use of the Association at its meeting. The Council shall also make all arrangements for the meetings of the Association, appointing such auxiliary committees from its own body, or from other members of the Association, and making such other provisions as shall be requisite, at its discretion.

# NOTE.

The accompanying volume, containing the proceedings, papers, and discussions of the American Medico-Psychological Association at its Seventy-fourth Annual Meeting, is printed by the Council with the approval of the Association.

H. W. MITCHELL,  
*Secretary.*

WARREN, PA.,  
*March 1, 1919.*

# AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

PROCEEDINGS OF THE SEVENTY-FOURTH ANNUAL MEETING.

CHICAGO, ILL., TUESDAY, JUNE 4, 1918.

## FIRST SESSION.

The Association convened at 10 a. m. in the red room of the Hotel La Salle, Chicago, Ill., and was called to order by the President, Dr. James V. Anglin, St. John, N. B.

**THE PRESIDENT.**—We are honored in having with us at this time one who appeals to us, as he has been with the regular United States Naval Training Station, and has already helped the Red Cross greatly by writing a play which has had wonderful vogue; I will ask Chaplain Charles W. Moore to pronounce the invocation.

Rev. Charles W. Moore, of the Great Lakes Naval Training Station, made the opening prayer.

**THE PRESIDENT.**—There are present with us to bid us welcome several distinguished gentlemen representing the state of Illinois and the city of Chicago as well as the medical profession. I would first call on Mr. W. T. Abbott, who has been delegated by His Excellency, Governor Lowden, to act as his substitute, the Governor being unable to be present.

**MR. ABBOTT.**—It is with mingled feelings of joy and regret that I bring you Governor Lowden's message. I share with the Governor and yourselves regret that he is unable to greet you in person. The only silver lining to that cloud is that it gives an opportunity to say some things which both his natural modesty and official discretion would forbid from his own lips.

So far as these brief remarks have any point outside of an unstudied and enthusiastic welcoming of your assembly to our city and state, they necessarily take this turn, the relation of the State to your Association. From time out of mind it has been assumed as the duty of every civilized state to care for its insane and feeble-minded. If a man loses a leg or arm he is not totally incapacitated for useful labor. He may even lose one or more of his five senses, yet be a helpful member of society and far from a burden to his family; but let reason desert her throne, then all present hope departs and the future is a wall of blackness, except as you and your fellow-workers set in motion the means to cure, or at least alleviate.

The manifest duty of the state as thus assumed, has in the past been executed with varying degrees of result, from the zenith of ability, honesty and efficiency to the nadir of absolute incompetence and brutality. It is largely due to the untiring efforts of your organization that many abuses of a generation ago exist no more.

There is a natural and inevitable limit to what the executive branch of any government can accomplish. It may take the necessary steps to raise and spend the money required to house and clothe the unfortunate, to provide them with suitable physical surroundings and to undertake the general financial and business administration. The problems of diagnosis, of research, of nursing, the administration of remedial agents of every kind, except physical surroundings, are purely professional, and lie beyond the proper scope of the political agencies of the state as such.

Little wonder, then, that such institutions have been the subject of complaint rather than commendation and have only occasionally been saved from total failure.

When each separate institution stood by itself, when, in Illinois, for example, all methods of housing and care, the purchase of all manner of supplies were scattered among 20 or more unorganized or disorganized heads, and the doctor in charge, besides his professional duties, was expected to participate in, if not absolutely direct, the business system and policy, it was asking too much of the best informed brain and the most enlightened conscience.

This plan of operation crowded to the limit upon the professional heads of our institutions the Biblical injunction: "Be ye therefore wise as serpents and harmless as doves." To be at least harmless in his professional diagnoses and remedial treatments, and in his business capacity, to combat successfully the ingenious wiles and schemes of politicians, contractors and purveyors of supplies, was a task at which the bravest might look askance or pass up utterly.

I need not speak for other states. In the last two years Illinois has laid the foundation for greater progress in the care of her defectives than in all her previous history. The ceaseless and well directed efforts of our Governor resulted, first, in the necessary legislative action, and, second, the administrative steps necessary to bring about a consolidation of the business management of all penal and charitable institutions under one efficient head, responsible only to the chief executive. This accomplishment requires at this time only the briefest mention, as I see it is to be the subject of a special paper. This goes a long way toward the solution of the problem so far as the state in its political capacity can secure improvement. Beyond this point, the attainment of perfection in such institutions in this state or elsewhere is your problem.

It may be true that so long as the appointment and tenure of office for professional heads of institutions is dependent upon the temporary success or set-back of political parties, the best men cannot always be found willing to accept those places. But is the remedy political? It certainly does not lie in a universal extension of civil service. What one of you

would accept such a place, knowing that the discharge of an incompetent, inhuman or personally offensive nurse or subordinate physician must be referred to some board or commission and an over-strained situation await weeks or months for decision.

It is for you to find the door out and to open it. In your researches you may discover that the only way out lies in a greater individual patriotism, a willingness on the part of your ablest men to accept these places, with all their drawbacks of uncertain tenure and at the temporary sacrifice of more adequate financial and professional returns from your private and personally conducted retreats.

I dare not remain long in attendance at your sessions. A mere reading of your program convinces me that I have all the symptoms of dementia praecox, which, to my lay mind, means anticipatory senility, and I am sure that a few hours' indulgence in the actual feast would provide me with more diseases than the youth of a generation ago had after reading Doctor Pierce's well known Yellow Book.

We shall watch your deliberations with honest interest, if not intelligence. That your stay in our midst may be both pleasant and profitable to yourselves, and that from your association here may result the greatest benefit to the helpless and unfortunate wards of our state, I know is the earnest wish of Governor Lowden, in whose name and behalf I have the honor to welcome you. (Applause.)

THE PRESIDENT.—Unfortunately Colonel Billings and Dr. Patrick, whose names appear on the program, are detained by military duty, but we are fortunate in having a substitute—Dr. Charles E. Humiston, President of the Chicago Medical Society.

DR. HUMISTON.—*Mr. Chairman, Members of the American Medico-Psychological Association, Ladies and Gentlemen:* It is a very pleasant duty to bring to you a word of greeting from the Chicago Medical Society. I am unable to say to you what Dr. Billings might wish to say, and shall not attempt to, but I shall attempt, and I expect to succeed, in a very few words to make you understand that we are glad you chose Chicago to hold this meeting in. As the family doctor is looked to for the cure of ills of physical health, so the profession in general looks to organizations such as yours and to your organization in particular for the solution of the problems to which you have addressed yourselves. Chicago is proud to welcome such distinguished visitors, and whatever we have of a medical nature is at your service, and when you have completed your deliberations I would in particular call your attention to the clinic which has been arranged at the Naval Training Station, and which is conducted by Dr. Hulbert, to which you are all most cordially welcome. (Applause.)

THE PRESIDENT.—Dr. H. Douglas Singer, representing the alienists of this district, and all of the state hospitals for the insane of Illinois, will say a few words to us.

DR. SINGER.—*Mr. President and Fellow-Members of this Association:* It gives me great pleasure to have the opportunity of welcoming you to

this state. As probably most of you know, Illinois is at the present time developing a new system of administration for its state institutions, concerning which I hope to have the pleasure of saying more to you tomorrow. The fact that this meeting is being held here at this particular time is consequently of the greatest value to this commonwealth. We expect to profit greatly from the deliberations of this body and to learn much which will assist us in planning the future of this new system which we believe will develop very great advantages as compared with that which we have had in the past. The system is still so new, having been in operation less than a year, that it is as yet not possible to make statements as to the results accomplished, but we do know that it is working smoothly.

There is one fact which might cause some hesitation with regard to starting such progressive work at this particular time—the fact that we are now at war. We all feel that perhaps under such circumstances nothing new ought to be undertaken; that, indeed, is one of the questions we have asked ourselves over and over again, but we feel that anything which will add to the efficiency with which the institutions are managed and which will result in economy of personnel and expenditures of various kinds is worth while during the war.

Doubtless many of you, like myself, have had much difficulty in deciding the question as to whether to stay in civil work or to enter the military service of the government. This is a question I should much like to hear discussed at this meeting. The sole consideration we all have in mind is that of doing the greatest service to the United States. At the present moment I personally feel that I am performing work which is essential but it is difficult, in the face of many appeals, to be entirely satisfied with this answer.

The work to which we are especially turning our energies is that of increasing efficiency; no attempt is being made to conduct scientific research in our institutions. I believe that the Department of Public Welfare of this state will receive great assistance from your deliberations and that this body can do a great service to those who remain at home by helping them to grasp the fact that they must be prepared to do more and better work while staying behind.

I wish to express to you a very hearty welcome from the Department of Public Welfare, and to say that the institutions of this state are open to you all and that you will be welcomed in any of them. There are several institutions in and near this city and we shall be glad to have any of you, who care to do so, pay them a visit.

THE PRESIDENT.—I am sure, ladies and gentlemen, that you will sanction my speaking when I say that we are all very grateful to these gentlemen for their hearty words of welcome. I think we have all decided that it was wise not to have altered our place of meeting this year, although some thought it would be best, owing to the restrictions placed on travel. Can we but for a few days become imbued with the spirit that dominates this western city, the meeting of 1918 will be a tremendous success. Again I thank you, gentlemen, on behalf of the Association for your kind words



of greeting, and assure you we will be pleased to have you remain for any or all of our sessions.

The next item on the program is the presentation of a service flag on behalf of the citizens of Chicago, by Frederick A. Brown, Esq., who will need no further introduction.

**MR. BROWN.**—*Mr. President, Members of this Association, Ladies and Gentlemen:* The war is no longer 3000 miles away; it is now being carried on in the very shadow of the Goddess of Liberty in New York Harbor. I think the German Government has misunderstood the psychology—shall I say—of its enemies. One of the things that has done so much to unite the people of the world against her was the Zeppelin raids over London; it united England; it encouraged the men to enlist and it gathered together that grand and splendid army with a will and determination to conquer that could hardly have existed under any other circumstances. And this U-boat raid off New York has appealed to the American people and has put down forever the idea that the war is 3000 miles away. I had an experience before the war that proved the absolute inability of the German mind to understand the American people. I was dining with a gentleman who had been a colonel in the German Army; at the same table was my friend, Colonel Robert L. Henry, of this city, who had served in our Civil War. The German colonel said: "My German regiment could land at New Orleans and march to New York City." Colonel Henry shook his head and said: "No, they couldn't do that; our police would arrest them." It has been said recently by Lloyd George that the American people have never been beaten. That is true. This reminds me of the story they tell of Napoleon in one of his great battles; he thought all was lost and turned to a little drummer boy who had served one of Napoleon's splendid generals, and said: "Boy, beat a retreat." The fellow raised his hand and said: "Sire, I never learned how to beat a retreat, General Desaix never taught me, but I can beat a charge that will wake the dead." And so with the American people, they know not defeat nor how to retreat. There can be but one outcome of this war that is now at our doors, and that is victory.

The people of the city of Chicago—and, notwithstanding the utterances of some of her citizens—a more loyal city in heart and soul does not exist on the American continent—have done me the honor to present to your organization a service flag in commemoration of nearly 100 of your members who have gone into this war. The taking part in this war by men trained as you are and educated as you are is almost an epoch in itself. Never before in any war has there been a body of men with but one purpose and that was to "minister to the mind diseased." Gentlemen, in the name of the people of the city of Chicago, I present to you this service flag. May the blue stars be many and the golden stars few. I thank you.

**THE PRESIDENT.**—Mr. Brown is Vice-President of the Illinois Bar Association, but he has a still greater honor—his only son is at the front. (Applause.)

To acknowledge this handsome gift Colonel Raymond had prepared an address. Unfortunately he is not here, neither is his address, so I will do the best I can as a substitute.

On your behalf, ladies and gentlemen, mine is the honor to accept this service flag from the generous citizens of Chicago, and assure these thoughtful patriots that this is the proudest hour in the history of our Association, when it is put in possession of tangible evidence of the number of men who have responded to the call of their country and will represent us on the battle line in the struggle between democracy and autocracy, between liberty and servitude, between honor and shame. Through you, sir, we would express our gratitude to the loyal people of this metropolis for the most appropriate souvenir of our stay amongst you. You may depend it will be hoarded as our most sacred treasure, and handled only when other stars are to be added to its folds.

All honor to the 93, a goodly number when we remember how many of our members are naturally beyond the age for active service in the field. There are banners, and *banners*; adorning these stately walls we have Old Glory with its stars from which liberty glows, and embosoming it the older interwoven crosses of St. George, St. Andrew and St. Patrick. While the Stars and Stripes and the Union Jack are here side by side, or flutter in the breeze together, as they are doing to-day in England, freedom will surely be safe.

They are now united against the eagle of Prussianism—the foe of all that we count dear in life, whose banner represents barbaric force and has for inscription, “Our glory is to slay.” The banner which to-day comes into our proud possession, emblem of the advance of science, bears but the single line: “Our duty is to save.” The men whom these stars indicate know the possible price and are ready to pay it, counting it worth while. If in the fortunes of war some of these stars shall change from blue to golden, there will be spots in a foreign land that shall be forever American. Their sacrifice will be no vain thing. Freedom has often cost a heavy price and once again it is doing so.

Gentlemen, if you approve of the Association's accepting this unique gift of a service flag, please indicate it by rising to your feet. (The entire audience rose at this point and applauded.) Mr. Brown, you have our expression of gratitude to the citizens of Chicago.

THE PRESIDENT.—The next in order is the report of the Committee of Arrangements, Dr. Sanger Brown, chairman.

#### REPORT OF COMMITTEE OF ARRANGEMENTS.

In deference to the strong nation-wide sentiment for conservation of resources and retrenchment, your committee has presumed to omit this year the excursions which have formed such delightful features of our meetings in years past, but we hope and trust that the efforts which our country is putting forth may largely and speedily contribute to the re-establishment and creation of conditions favorable to all sorts of legitimate recreation.

After the Annual Address on Wednesday evening there will be a reception in the red room, with light refreshments and dancing.

The society is invited by the commandant, Colonel Moffatt, to visit the Naval Training Station at Lake Bluff. We will be afforded an opportunity to see in vogue recent methods of classifying on a psychological basis recruits for various departments of naval and military service. This work is being done by Dr. Hulbert, who holds his clinic at 12.30 p. m. The Henry Flavill School, formerly the Illinois Society for Mental Hygiene, has invited our members to luncheon on Thursday. This institution is next door to the celebrated Hull House, so ably presided over for many years by Miss Jane Addams, and you will have an opportunity of visiting Hull House and probably meeting Miss Addams.

SANGER BROWN, *Chairman.*

THE PRESIDENT.—I will call on the Secretary for the report of the Council.

#### REPORT OF THE COUNCIL TO THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

CHICAGO, ILL., June 4, 1918.

The Council met on the evening of June 3, 1918, at the Hotel LaSalle, Chicago, Ill.

The Council recommends for election to active membership the following named physicians. This list was presented to the Association a year ago, and these names are now submitted for final consideration:

G. E. Charlton, M. D., Norfolk, Neb.; Harvey Clare, M. D., Toronto, Ont.; Albert H. Dollear, M. D., Jacksonville, Ill.; Winfield S. Farmer, M. D., Nashville, Tenn.; William S. Fast, M. D., Ingleside, Neb.; William Healy, M. D., Boston, Mass.; C. C. Kirk, M. D., Little Rock, Ark.; William T. Kradwell, M. D., Wauwatosa, Wis.; Lesser Kauffman, M. D., Buffalo, N. Y.; F. G. Larue, M. D., Hopkinsville, Ky.; Arthur P. Noyes, M. D., Boston, Mass.; W. Reid Putney, M. D., Amelia, Va.; Ralph Reed, M. D., Cincinnati, O.; Arthur H. Ring, M. D., Arlington Heights, Mass.; Delparde W. Roberts, M. D., Milwaukee, Wis.; Rock Sleysler, M. D., Waupun, Wis.; William J. Steward, M. D., Pennhurst, Pa.; Beverly R. Tucker, M. D., Richmond, Va.; Fulton S. Vrooman, M. D., Coburg, Ont.; Samuel B. Woodward, M. D., Worcester, Mass.; A. R. T. Wylie, M. D., Grafton, N. D.

The Council recommends for election to honorary membership in the Association:

Noboru Ishida, M. D., of Nagasaki, Japan, Professor of Phychiatry in the Nagasaki Medical College and Chief Psychiatrist to the Prefectural Hospital.

The Council recommends the transfer of the following named associate members to the active class:

Amos T. Baker, M. D., East View, N. Y.; E. S. Brodsky, M. D., Bridgeport, Conn.; J. F. Leigh Brown, M. D., Woodstock, N. B.; Chester Lee Carlisle, M. D., Albany, N. Y.; Alan D. Finlayson, M. D., Warren, Pa.;

P. T. Haskell, M. D., Bangor, Me.; Harlan P. Mills, M. D., Phoenix, Ariz.; E. A. North, M. D., Cincinnati, O.; E. Palmer, M. D., Ann Arbor, Mich.; Leigh F. Robinson, M. D., Hartford, Conn.; William J. Tiffany, M. D., Binghamton, N. Y.; Pearl S. Waters, M. D., Fergus Falls, Minn.; Lorne W. Yule, M. D., Logansport, Ind.; R. G. Barry, M. D., Trenton, N. J.

The Council recommends that the following named physicians be elected to associate membership:

Harry B. Ballou, M. D., Westborough, Mass.; H. A. Bolton, M. D., Warm Springs, Mont.; Clarence A. Bonner, M. D., Worcester, Mass.; J. W. Brophy, M. D., Warm Springs, Mont.; Nathaniel H. Brush, M. D., Baltimore, Md.; Homer L. Day, M. D., New York; Flora Parker Easton, M. D., Norristown, Pa.; Mary L. Evans, M. D., Middletown, Conn.; K. M. Ferguson, M. D., Massillon, O.; James J. Gable, M. D., Norman, Okla.; Ada F. Harris, M. D., Worcester, Mass.; F. Ross Haviland, M. D., New York; Elizabeth S. Helberg, M. D., New York; Herbert E. Herrin, M. D., Concord, N. H.; Bertrand L. Jones, M. D., Ann Arbor, Mich.; James P. Kelleher, M. D., New York; Howard M. Kenyon, M. D., Binghamton, N. Y.; Marie S. Lindsay, M. D., Worcester, Mass.; Mary MacLachlin, M. D., Middletown, Conn.; Alexander R. MacKenzie, M. D., Huntington, W. Va.; George W. Melvin, M. D., Middletown, Conn.; George W. T. Mills, M. D., Central Islip, N. Y.; Cora B. Palmer, M. D., Logansport, Ind.; Oscar J. Raeder, M. D., Boston, Mass.; Jonathan H. Ranney, M. D., Brattleboro, Vt.; Charles E. Rowe, M. D., Binghamton, N. Y.; Joseph Slattery, M. D., Massillon, O.; Arthur E. Soper, M. D., New York; Dwight S. Spellman, M. D., New York; Francis Albert Taylor, M. D., Middletown, Conn.; L. E. Trent, M. D., Nashville, Tenn.; Chester A. VanCor, M. D., Middletown, Conn.; Rodney R. Williams, M. D., Binghamton, N. Y.

The Council has received the following applications for active membership. In accordance with the constitution, final consideration of these will be deferred until next year:

James A. Belyea, M. D., Toledo, O.; Louis E. Bisch, M. D., New York; Frank H. Carlisle, M. D., Bridgewater, Mass.; Clarence J. D'Alton, M. D., New York City; Spencer L. Dawes, M. D., Garden City, N. Y.; Frank I. Drake, M. D., Mendota, Wis.; R. A. Kidd, M. D., Shepherd, O.; Lawrence Kolb, M. D., New York; Lawson G. Lowrey, M. D., Boston, Mass.; J. C. Michael, M. D., St. Paul, Minn.; Fred P. Moersch, M. D., Minneapolis, Minn.; G. C. Robertson, M. D., Spencer, W. Va.; Thomas A. Rutherford, M. D., Clark's Summit, Pa.; John W. Stevens, M. D., Nashville, Tenn.; John R. Walls, M. D., Phoenix, Ariz.; C. E. White, M. D., Weston, W. Va.; Otto G. Wiedman, M. D., Hartford, Conn.; Porter E. Williams, M. D., St. Joseph, Mo.; Henry W. Woltmann, M. D., Minneapolis, Minn.

The Council has received the resignations of the following members, and recommends that they be accepted in so far as their dues are paid to date:

E. Mabel Thompson, M. D., Somyea, N. Y.; Donald Campbell Meyers, M. D., Toronto, Ont.; William L. Robins, M. D., Washington, D. C.; C. Ross Miller, M. D., Colorado Springs, Colo.; George T. Faris, M. D., Phila-

delphia, Pa.; Edward B. Shellenberger, M.D., Danville, Pa.; Philip C. Washburn, M.D., Kings Park, N. Y.; John J. Harrington, M.D., Osawatomie, Kans.; John C. Felty, M.D., Gettysburg, Pa.; Herbert B. Howard, M.D., Boston, Mass.

The Council recommends that memorial notices, or abstracts of the same, be read when the writers are present.

The Council recommends that the following resolution be adopted by the Association:

*Whereas*, Many of the members of the American Medico-Psychological Association have answered the call to colors; and

*Whereas*, By their patriotic love for their country and their belief in human freedom, they have sacrificed their positions, have broken their family ties and have placed their lives upon the altar of devotion; therefore, be it

*Resolved*, That, as a slight token of esteem for these patriots, we the American Medico-Psychological Association do hereby authorize the Treasurer of this Association to remit dues of such members during their terms of active service.

The Council makes the following further recommendations:

That no reprints from the *JOURNAL* or *Transactions* be furnished to writers of papers until further action, except at the expense of the authors.

That the Treasurer be authorized to reimburse Dr. Hoisholt for the expense of the moving picture film in connection with his paper, but that this action shall not be considered as establishing a precedent.

That the resignations of Dr. Henry M. Hurd and Dr. G. Alder Blumer as members of the editorial board of *THE AMERICAN JOURNAL OF INSANITY* be accepted, and the name of each be carried on the title page of the *Journal* as editor emeritus; that Dr. Charles Macfie Campbell, of Baltimore, Md., and Dr. Albert M. Barrett, of Ann Arbor, Mich., be added to the editorial board of the *JOURNAL* to fill the vacancies.

That the annual meeting of the Association be held in Philadelphia, Pa., in 1919, the date to be determined by the President and the Secretary.

Respectfully submitted,

H. C. EYMAN, *Secretary*.

DR. S. E. SMITH.—I move that the report of the Council be accepted and adopted, and that the resolution in regard to the remission of dues be adopted by the Association.

The motion was duly seconded and carried.

At the suggestion of the President, Dr. E. N. Brush escorted Professor Ishida, the newly-elected honorary member, to the platform and presented him to the Association.

THE PRESIDENT.—We will now have the report of the Treasurer.

The following is a statement of membership of the American Medico-Psychological Association to date:

## HONORARY MEMBERS.

Present number .....	18
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## LIFE MEMBERS.

Former number .....	27
Added .....	4
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Total .....	31
Died .....	1
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Present number .....	30

## ACTIVE MEMBERS.

Former number .....	462
Associate to Active .....	18
Admitted .....	28
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Total .....	508
Active to Life .....	4
Resigned .....	3
Dropped .....	7
Died .....	4
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Total .....	18
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Present number .....	490

## ASSOCIATE MEMBERS.

Former number .....	338
Admitted .....	34
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Total .....	372
Associate to Active .....	18
Resigned .....	8
Dropped .....	4
Died .....	1
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Total .....	31
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Present number .....	341
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Grand total membership May 29, 1918.....	879

## REPORT OF TREASURER, 1917-1918.

## DEBITS.

Balance brought forward .....	\$4592.90
Receipts for dues:	
Active members .....	2140.00
Associate members .....	518.00
Advance dues .....	11.00
Interest on deposits:	
First National Bank, Massillon.....	78.12
Mutual Building & Investment Co., Cleveland, Ohio..	91.33
Miscellaneous:	
Gummed lists of members .....	7.50
Refund, Astor Hotel .....	12.50
Exchange on checks .....	.20
 Total receipts .....	 2858.65
Total debits .....	\$7451.55

1917

## CREDITS.

May	30	T. E. McGarr, stenographic services .....	\$75.00
	30	R. H. Hutchins, industrial exhibit expense .....	10.55
	30	H. M. Pollock, printing statistical report .....	47.30
June	4	H. C. Eyman, Secretary, incidental expenses, New York meeting .....	10.57
	6	E. G. Conklin, expenses—annual address.....	50.00
	6	W. C. Muschenheim, stereopticon, placards, etc.....	23.50
	15	A. H. Harrington, stereopticon, rental.....	12.00
	15	Ohio Printing & Publishing Co., printing reports and letter heads .....	4.50
	23	Ohio Printing & Publishing Co., letter heads and cards.....	18.85
July	11	T. E. McGarr, stenographic services.....	75.00
Aug.	7	E. A. Rigdon, express .....	.91
	20	Lord Baltimore Press, printing <i>Transactions</i> .....	1539.98
	20	T. E. McGarr, stenographic services .....	15.00
	22	Johns Hopkins Press, to apply on deficit—institutional care of the insane .....	2500.00
Oct.	15	Lord Baltimore Press, expense <i>Transactions</i> .....	24.39
	15	John W. Jones, supplies .....	3.05
	19	Sheppard-Enoch Pratt Hospital, paper, postage, etc....	18.33
	25	Ohio Printing & Publishing Co., letter heads and printing .....	46.75
	25	H. C. Eyman, Secretary, expense to Chicago—meeting on arrangements .....	30.00
Nov.	1	William R. Dunton, indexing <i>Transactions</i> .....	29.00
	1	John W. Jones, envelopes .....	2.45
	12	E. A. Rigdon, stamps and express .....	5.77

1918

## CREDITS.

Jan.	12	E. A. Rigdon, postage .....	2.00
	25	E. A. Rigdon, stamps .....	5.00
	25	Miss Beulah Harpold, stenographic services 1 year....	100.00
Feb.	28	H. W. Mitchell, expenses to Chicago, including printing, etc.....	66.97
	28	H. C. Eyman, expenses to Chicago .....	30.00
Mch.	7	Western Union Telegraph Co., telegrams.....	3.30
	7	Ohio Printing & Publishing Co., envelopes.....	33.25
	16	H. B. Sibila, P. M., stamps.....	40.00
Apr.	9	Ohio Printing & Publishing Co., printing preliminary programs .....	11.00
	18	Ohio Printing & Publishing Co., envelopes and receipts.	5.80
	18	E. A. Rigdon, stamps .....	1.00
	24	E. A. Rigdon, stamps .....	1.50
May	8	E. A. Rigdon, stamps.....	.50
	17	E. A. Rigdon, stamps .....	7.50
	23	The Independent Co., registration cards.....	4.00
	24	E. A. Rigdon, clerical services and supplies.....	35.35
	27	Ohio Printing & Publishing Co., printing programs, envelopes, and dodgers .....	128.25
	27	The Park Press, printing ballots .....	4.00
Total expenditures .....			\$5022.32
By refunds and protested checks.....			15.00
Bank balance, First National Bank, Massillon.....			1970.10
Mutual Building & Investment Co., Cleveland, Ohio....			444.13

Total ..... \$7451.55

Respectfully submitted,

H. C. EYMAN, *Treasurer.*

DR. WAGNER.—I move the report of the Treasurer be received and referred to the auditors.

THE PRESIDENT.—I will call for the report of the editors of the AMERICAN JOURNAL OF INSANITY.

DR. BRUSH.—

*To the Members of the American*

*Medico-Psychological Association,*

The Editorial Board of the AMERICAN JOURNAL OF INSANITY held a meeting in New York on May 16th. At this meeting, there were present Dr. Henry M. Hurd, G. Alder Blumer, J. Montgomery Mosher, and the speaker. I was able to report the affairs of the JOURNAL in an excellent condition.

The seventy-fourth volume just completed comprises more than 725 pages with more than 50 illustrations, the majority of which are half-tone plates.



The increased cost of paper, composition and press work has very materially increased the cost of publishing the JOURNAL, but, as will be seen from the financial report of the publishers, we close the year with a comfortable balance. It is not impossible that the next volume will, of necessity, be restricted in size, owing to the shortage of paper.

It is hoped that the papers read at this session will be sent to the Secretary ready for the printer. Too often contributors, when they receive the proof-sheets of their papers, make very material alterations therein, often to the extent of re-writing whole pages. This is expensive to the JOURNAL, and, in the future, changes in proof other than ordinary proof corrections will be charged to the authors making such changes.

The Council has adopted a rule that until further notice, reprints, which have heretofore been furnished to the number of one hundred gratis to authors, will be charged for at cost.

It is with much regret that I was compelled to offer to the Council the resignations of Drs. Hurd and Blumer from the Board, which were presented to me at the meeting in May of the Editorial Board. I shall long miss their advice and co-operation, and the readers of the JOURNAL will share with me in the regret that they have felt compelled to leave the Editorial Board.

In the election of Drs. Charles Macfie Campbell and Albert M. Barrett to fill the vacancies in the board, a very wise choice has been made as I am confident will be demonstrated in the future.

Respectfully submitted,

EDWARD N. BRUSH, *Managing Editor*.

DR. BURGESS.—I move that the report of the editors of the JOURNAL be received and the financial part referred to the auditors.

Motion seconded and adopted.

THE PRESIDENT.—It is the duty of the President at this time to appoint a Nominating Committee. I shall name as that committee the following: Dr. T. J. W. Burgess, Quebec; Dr. Charles W. Pilgrim, New York; Dr. Byron M. Caples, Wisconsin.

Another committee that I will name at this time is the Committee on Awards: Dr. Albert M. Barrett, Michigan; Dr. Alfred T. Hobbs, Ontario; Mrs. Sanger Brown, Illinois; Mrs. Charles P. Bancroft, New Hampshire; Mrs. T. J. W. Burgess, Quebec; Mrs. Edward N. Brush, Maryland.

We will dispense with the recess for registration and go on with the program if it is the wish of the Association.

I will ask the Secretary to read the list of those who have died during the year; the members will please stand while these names are being read.

The following list of memorial notices was read by the Secretary:

Dr. John B. Chapin, by Edward N. Brush, M. D.; Dr. Charles H. North, by R. F. C. Kieb, M. D.; Dr. George Villeneuve, by Frank E. Devlin, M. D.; Dr. Thomas G. Biddle, by M. L. Perry, M. D.; Dr. James H. Garlick, by

J. S. DeJarnette, M. D.; Dr. H. V. A. Smith, by George W. King, M. D., and Dr. William Austin Macy.

Dr. Brush read an abstract of the memorial notice of Dr. Chapin; the writers being absent, the remainder of the memorial notices were read by title.

THE PRESIDENT.—There is but one other item on the morning's program, and that is the presidential address.

The President then read his address, which was received with prolonged applause.

DR. C. B. BURR.—These golden, glowing, glorious words of our President have not fallen on unappreciative ears; we are with you, Mr. President, in every word you have uttered. You have no foolish optimism; you do not indulge in any self-cheating; you have your face set to the front, and God grant that we may all be similarly minded and similarly determined—I believe we are, and if we are, why nothing but victory for the Allies can result, however long this awful war may continue. Just one word more; you have spoken about the last gun; it may be that it will be fired by an American; it may be by a French, Italian, British, or Belgian battery; I do not want to know which. All I wish to know is that it is fired from a gun of one of the Allies. Let us submerge nationalism just as far as is consistent and think in terms of internationalism in its broadest and best significance.

Mr. Vice-President, I move a vote of thanks to the President of this Association for his address.

DR. SOUTHARD (presiding).—I will put this motion and ask that we have a rising vote of the Association.

The motion was unanimously carried by a rising vote.

The following members registered and were in attendance during the whole or a part of the meeting:

Abbot E. Stanley, M. D., Assistant Physician & Pathologist, McLean Hospital, Waverley, Mass.

Adams, F. M., M. D., Superintendent Eastern Oklahoma Hospital, Vinita, Okla.

Adler, Herman M., M. D., 1812 W. Polk St., Chicago, Ill.

Amsden, George S., M. D., Senior Assistant Physician Bloomingdale Hospital, White Plains, N. Y.

Anderson, Albert, M. D., Superintendent State Hospital, Raleigh, N. C.

Anglin, J. V., M. D., Medical Superintendent The Provincial Hospital, St. John, N. B.

Ballintine, Eveline P., M. D., Assistant Physician State Hospital, Rochester, N. Y.

Bancroft, Charles P., M. D., 104 Pleasant St., Concord, N. H.

Barrett, Albert M., M. D., Medical Director State Psychopathic Hospital, University of Michigan, Ann Arbor, Mich.

Beutler, W. F., M. D., Superintendent Milwaukee Asylum for Mentally Diseased, Wauwatosa, Wis.

Brill, A. A., M. D., No. 1 West 70th St., New York, N. Y.

Brown, G. W., M. D., Superintendent Eastern State Hospital, Williamsburg, Va.

Brown, Sanger, M. D., Chief-of-Staff Kenilworth Sanitarium, Kenilworth, Ill.

Bryan, W. A., M. D., Assistant Superintendent Danvers State Hospital, Hathorne, Mass.

Brush, Edward N., M. D., Physician-in-Chief and Superintendent Shepard and Enoch Pratt Hospital, Towson, Md.

Burgess, T. J. W., M. D., Medical Superintendent Protestant Hospital for the Insane, Montreal, Quebec.

Burnet, Anne, M. D., 6352 Kenwood Ave., Chicago, Ill.

Burr, C. B., M. D., Medical Director Oak Grove Hospital, Flint, Mich.

Caples, B. M., M. D., Superintendent Waukesha Springs Sanitarium, Waukesha, Wis.

Carlisle, Frank H., M. D., Medical Director Bridgewater State Hospital, Bridgewater, Mass.

Carmichael, F. A., M. D., Superintendent Osawatomie State Hospital, Osawatomie, Kans.

Carriel, H. B., M. D., Superintendent Dixon State Colony, Dixon, Ill.

Church, Mary V., M. D., Assistant Physician Southern Indiana Hospital for Insane, Evansville, Ind.

Cobb, O. H., M. D., Superintendent Syracuse State Institution, Syracuse, N. Y.

Cohn, Eugene, M. D., Superintendent Kankakee State Hospital, Kankakee, Ill.

Crumbaker, W. P., M. D., Superintendent Independence State Hospital, Independence, Ia.

Dewey, Richard, M. D., Medical Superintendent Milwaukee Sanitarium, Wauwatosa, Wis.

Dolloff, Charles H., M. D., Superintendent New Hampshire State Hospital, Concord, N. H.

Donohoe, George, M. D., Medical Superintendent Cherokee State Hospital, Cherokee, Ia.

Dowell, R. T., M. D., Assistant Physician Elgin State Hospital, Elgin, Ill.

English, W. M., M. D., Superintendent Hospital for Insane, Hamilton, Ont., Canada.

Eyman, Henry C., M. D., Superintendent Massillon State Hospital, Massillon, Ohio.

Faison, W. W., M. D., Superintendent State Hospital, Goldsboro, N. C.

Farmer, W. F., M. D., Superintendent Central Hospital for Insane, Nashville, Tenn.

- Fast, William S., M. D., Superintendent State Hospital, Ingleside, Neb.
- Foley, Edward A., M. D., Assistant Superintendent Chicago State Hospital, Dunning, Ill.
- Forster, J. M., M. D., Superintendent Hospital for Insane, Toronto, Ont., Canada.
- Fuller, Daniel H., M. D., Sr. Asst. Physician Pennsylvania Hospital, 49th and Market Sts., Philadelphia, Pa.
- Fuller, Solomon C., M. D., Pathologist and Clinical Director Westborough State Hospital, Westborough, Mass.
- Gahagan, H. J., M. D., Medical Director Mercyville Sanitarium, Aurora, Ill.
- Glueck, Bernard, M. D., Director Psychopathic Clinic, Sing Sing Prison, Ossining, N. Y.
- Gorst, Charles, M. D., 711 E. Gorham St., Madison, Wis.
- Gosline, Harold I., M. D., Base Hospital, U. S. A., Camp Sherman, Chillicothe, Ohio.
- Goss, Arthur V., M. D., Superintendent Taunton State Hospital, Taunton, Mass.
- Griffin, D. W., M. D., Superintendent Central Oklahoma State Hospital, Norman, Okla.
- Guthrie, L. V., M. D., Superintendent Huntington State Hospital, Huntington, W. Va.
- Haines, Thomas H., M. D., Professor of Medicine Ohio State University, Columbus, Ohio.
- Hawley, M. C., M. D., Superintendent Watertown State Hospital, East Moline, Ill.
- Herriman, William C., M. D., Medical Director Hospital for Feeble-Minded, Orillia, Ont., Canada.
- Hill, Charles G., M. D., Physician-in-Chief Mt. Hope Retreat, Baltimore, Md.
- Hinton, Ralph T., M. D., Superintendent Elgin State Hospital, Elgin, Ill.
- Hobbs, A. T., M. D., Superintendent Homewood Sanitarium, Guelph, Ontario, Canada.
- Hoisholt, A. W., M. D., Superintendent Napa State Hospital, California.
- Horner, Blanche W., M. D., Assistant Physician Rochester State Hospital, Rochester, Minn.
- Hotchkiss, W. M., M. D., Superintendent North Dakota State Hospital, Jamestown, N. Dak.
- Howell, D. H., M. D., Assistant Physician Chicago State Hospital, Chicago, Ill.
- Hyde, George E., M. D., Superintendent State Mental Hospital, Provo, Utah.
- Ishida, N., M. D., Professor of Nagasaki Medical College, Nagasaki, Nagasaki Prefectural Hospital, Nagasaki, Japan.
- Jackson, James Allen, M. D., Chief Resident Physician Philadelphia Hospital for Insane, Philadelphia, Pa.

Jones, L. M., M.D., Superintendent Georgia State Sanitarium, Milledgeville, Ga.

Kilbourne, Arthur F., M.D., Superintendent Rochester State Hospital, Rochester, Minn.

King, George W., M.D., Medical Director Hudson County Hospital, Secaucus, N. J.

Kirby, George H., M.D., Director Psychiatric Institute, Ward's Island, New York City.

Kline, George M., M.D., Director Massachusetts Commission on Mental Diseases, State House, Boston, Mass.

Klopp, Henry I., M.D., Superintendent State Hospital, Allentown, Pa.

Kradwell, William T., M.D., Assistant Superintendent Milwaukee Sanitarium, Wauwatosa, Wis.

LaMoure, H. A., M.D., Superintendent Colorado State Hospital, Pueblo, Colo.

Langdon, Frank W., M.D., Medical Director Cincinnati Sanitarium, 4003 Rose Hill Ave., Cincinnati, O.

Laughlin, C. E., M.D., Superintendent Southern Indiana Hospital for the Insane, Evansville, Ind.

Leader, Pauline M., M.D., Attending Physician Clarinda State Hospital, Clarinda, Ia.

Leak, R. L., M.D., Medical Director State Hospital for Insane, Columbia, S. C.

Lowe, Charles R., M.D., Lincoln State School and Colony, 861 S. State St., Lincoln, Ill.

Mitchell, H. W., M.D., Superintendent State Hospital for the Insane, Warren, Pa.

Mitchell, J. C., M.D., Superintendent Eastern Hospital, Brockville, Ont., Canada.

Orton, Samuel T., M.D., Clinical Director and Pathologist Pennsylvania Hospital, 4401 Market St., Philadelphia, Pa.

Ostrander, Herman, M.D., Superintendent Kalamazoo State Hospital, Kalamazoo, Mich.

Palmer, E., M.D., Senior Assistant Physician Northern Hospital for Insane, Logansport, Ind.

Payne, Guy, M.D., Superintendent Essex County Hospital, Cedar Grove, N. J.

Perry, M. L., M.D., Superintendent Topeka State Hospital, Topeka, Kan.

Pierson, Clarence, M.D., Superintendent East Louisiana Hospital, Jackson, La.

Pietrowicz, Stephen R., M.D., Physician-in-Chief St. Mary's Hospital, 5733 Sheridan Road, Chicago, Ill.

Pilgrim, Charles W., M.D., Chairman State Hospital Commission, Poughkeepsie, N. Y.

Pogue, Mary E., M.D., Superintendent Mary E. Pogue Sanitarium, Wheaton, Ill.

Prout, Thomas P., M. D., Superintendent Fair Oaks Sanitarium, Summit, N. J.

Quinn, F. W., M. D., Assistant Physician Louisiana Hospital for the Insane, Pineville, La.

Raeder, O. J., M. D., Assistant Pathologist Psychopathic Hospital, 74 Fenwood Road, Boston, Mass.

Read, Charles F., M. D., Managing Officer Chicago State Hospital, Chicago, Ill.

Ridgway, R. F. L., M. D., First Assistant Physician Pennsylvania State Lunatic Hospital, Harrisburg, Pa.

Roberts, D. W., M. D., Chief-of-Staff Sacred Heart Sanitarium, Minneapolis, Minn.

Robertson, G. C., M. D., Superintendent Spencer State Hospital, Spencer, W. Va.

Ross, Charles E., M. D., Wichita, Kan.

Seybert, Frank T., M. D., Physician-in-Chief St. Bernard's Hospital, Council Bluffs, Ia.

Sherman, Adin, M. D., Superintendent The Northern Hospital for Insane, Winnebago, Wis.

Singer, H. Douglas, M. D., State Alienist Department Public Welfare, Kankakee, Ill.

Smith, Samuel E., M. D., Medical Superintendent Eastern Indiana Hospital for Insane, Richmond, Ind.

Snavelly, Earl H., M. D., Assistant Physician Essex County Hospital, Cedar Grove, N. J.

Southard, E. E., M. D., Pathologist Massachusetts Commission Mental Diseases, 74 Fenwood Road, Boston, Mass.

Spaulding, Edith R., M. D., Director Psychopathic Hospital, Bedford Hills, N. Y.

Stearns, A. W., M. D., U. S. N. R. F., 520 Commonwealth Ave., Boston.

Terflinger, F. W., M. D., Superintendent Northern Indiana Hospital for Insane, Logansport, Ind.

Treadway, W. L., M. D., Passed Assistant Surgeon U. S. P. H. S., 416 Winder Building, Washington, D. C.

Tuttle, George T., M. D., Superintendent McLean Hospital, Waverley, Mass.

Tyson, Forrest C., M. D., Superintendent Augusta State Hospital, Augusta, Me.

Uhls, L. L., M. D., The Uhls Sanitarium, Overland Park, Kan.

VanNuys, W. C., M. D., Superintendent Indiana Village for Epileptics, Newcastle, Ind.

Wade, J. Percy, M. D., Superintendent Spring Grove State Hospital, Catonsville, Md.

Wagner, Charles G., M. D., Superintendent Binghamton State Hospital, Binghamton, N. Y.

Walsh, James J., M. D., Assistant Physician Elgin State Hospital, Elgin, Ill.

Waters, Pearl S., M. D., Staff Physician Fergus Falls State Hospital, Fergus Falls, Minn.

Wenglesky, J. F., M. D., Physician-in-Charge St. Mary's Hill, Milwaukee, Wis.

Wilgus, Sidney D., M. D., Proprietor Wilgus Sanitarium, Rockford, Ill.

Williams, B. F., M. D., Lincoln, Neb.

Williams, C. F., M. D., Superintendent State Hospital for Insane, Columbia, S. C.

Williams, Frankwood E., M. D., Associate Medical Director National Committee for Mental Hygiene, Surgeon General's Office, Washington, D. C.

Woodson, C. R., M. D., Superintendent Woodson Sanitarium, St. Joseph, Mo.

Young, A. F., M. D., Superintendent Milwaukee County Hospital for Mental Diseases, Wauwatosa, Wis.

Yule, Lorne W., M. D., Roanoke, Va.

Zeller, George A., M. D., Managing Officer Alton State Hospital, Alton, Ill.

The following visitors and guests of the Association registered their names with the Secretary :

Abbot, Mrs. E. Stanley, Waverley, Mass.

Abbott, Mr. William T., Central Trust Co., Chicago, Ill.

Adams, B. O., Riverside, Cal.

Amsden, Mrs. George S., White Plains, N. Y.

Anderson, C. H., Managing Officer Anna State Hospital, Anna, Ill.

Anglin, Mrs. J. V., St. John, N. B., Canada.

Arnold, Mrs. Frances D., 1456 Fargo Ave., Chicago, Ill.

Ashurhurst, T. E., Waurika, Okla.

Bancroft, Mrs. Charles P., Concord, N. H.

Barber, Helen M., 1230 N. State St., Chicago, Ill.

Beutler, Mrs. W. F., Wauwatosa, Wis.

Bond, Miss Edith, Chicago, Ill.

Boyd, C. A., 208 W. Monroe St., Chicago, Ill.

Brush, Mrs. Edward N., Windy Brae, Towson, Md.

Buffington, Sarah Louise, 1140 Forest Ave., Evanston, Ill.

Burgess, Mrs. T. J. W., Montreal, Canada.

Burr, Mrs. C. B., Oak Grove, Flint, Mich.

Caples, Mrs. Byron M., Waukesha, Wis.

Chenoweth, Mrs., Montreal, Canada.

Chidester, F., Watertown State Hospital, E. Moline, Ill.

Comstock, C. F., Chicago, Ill.

Davies, David H., Board of Administration Milwaukee County, Wauwatosa, Wis.

Dearman, U. L., M. D., Reedy, Iowa.

Eyman, Ethel C., Matron State Hospital, Massillon, Ohio.

Ferrier, E. G., M. D., Chicago State Hospital, Dunning, Ill.

Ferrer, Harold C., 4003 N. Hamlin Ave., Chicago, Ill.

- Foster, Mrs. Edgar, Mt. Carmel, Ill.  
Fry, George C., 34 Columbus Ave., Boston, Mass.  
Goff, E. S., Spencer, W. Va.  
Gorst, Mrs. Charles, 747 Irving Park Boulevard, Chicago, Ill.  
Gosline, Mrs. H. I., Camp Sherman, Chillicothe, O.  
Greenacre, Phyllis, M. D., Assistant in Psychiatry Phipps Clinic, Johns Hopkins Hospital, Baltimore, Md.  
Griffith, Nina, Evanston, Ill.  
Guthrie, Mrs. L. V., Matron Huntington State Hospital, Huntington, W. Va.  
Hadley, Mildred E., 801 Hinman Ave., Evanston, Ill.  
Hincks, Clarence M., M. D., Canadian National Committee for Mental Hygiene, Toronto, Canada.  
Hobbs, Mrs. A. T., Homewood Sanitarium, Guelph, Ont., Canada.  
Hoefler, William H., Chicago, Ill.  
Hoff, J. J., M. D., Staff of Chicago State Hospital, Dunning.  
Hoisholt, Mrs. A. W., Napa State Hospital, Napa, Cal.  
Hoisholt, Miss, Napa State Hospital, Napa, Cal.  
Holmes, Bayard, M. D., 30 N. Michigan Ave., Chicago, Ill.  
Hotchkiss, Mrs. W. M., Jamestown, N. Dak.  
Hotchkiss, Douglas, Jamestown, N. Dak.  
Hoye, M. J. L., M. D., Superintendent East Mississippi Insane Hospital, Meridian, Miss.  
Humiston, Charles E., M. D., President Chicago Medical Society, Chicago, Ill.  
Johnson, J. E., Cincinnati, Ohio.  
Kilbourne, Mrs. Arthur F., Rochester, Minn.  
Kilbourne, Miss Katharine, Rochester, Minn.  
Kinerem, Frank, Davenport, Iowa.  
Koschel, B. R., Wyandotte, Mich.  
Larson, Daniel O., M. D., State Mental Hospital, Provo, Utah.  
Laughlin, E., D. D. S., 7th Reg., Camp Terry, Great Lakes, Ill.  
Laughlin, Emma, Matron, Woodmere, Evansville, Ind.  
Laughlin, Genevieve, So. Indiana Hospital for the Insane, Evansville, Ind.  
Lermit, Geraldine R., 5211 Cornell Ave., Chicago, Ill.  
Ludolph, A. E., Wyandotte, Mich.  
Maginnis, F. N., M. D., Assistant Superintendent Mercyville Sanitarium, Aurora, Ill.  
McCarty, Charles W., New York City.  
McCarthy, W. P., 208 W. Monroe St., Chicago, Ill.  
McIntire, Annette M., M. D., 25 E. Washington St., Chicago.  
Monroe, Mrs. William S., President Illinois Society for Mental Hygiene, 64 E. Elm St., Chicago, Ill.  
Moyer, Harold N., 202 S. State St., Chicago, Ill.  
Ostrander, Jessie M., New York City.  
Pollock, Horatio M., Statistician New York State Hospital Commission, Albany, N. Y.  
Quin, Mrs. F. W., Pineville, La.



Raymond, Henry I., M. D., Colonel Medical Corps, U. S. Army, Department Surgeon, Chicago.

Ririe, Joseph, M. D., Member Board of Insanity of Utah, Ogden, Utah.

Royal, Mrs. George, 229 Wesley Ave., Oak Park, Ill.

Sasano, K. T., M. D., Lakeside, Chicago, Ill.

Sherman, Mrs. Adin, Winnebago, Wis.

Slagle, Eleanor Clarke, Director Occupational Therapy, Public Welfare Department, Hull House, Chicago, Ill.

Spencer, Ethel M., 109 Wade St., Highland Park, Ill.

Smith, Charlotte T., 1230 N. State St., Chicago, Ill.

Smith, H. Mason, M. D., Superintendent Florida Hospital for the Insane, Chattahoochee, Fla.

Staples, Katharine C., 1125 Davis St., Evanston, Ill.

Stevens, H. Campbell, M. D., Physician Chicago State Hospital, Dunning, Ill.

Stevens, Elmer A., M. D., Commissioner of Mental Diseases, 55 Federal St., Boston, Mass.

Sutherland, L. B., Ringling, Okla.

Sutton, Bess E., Flavill School of Occupation, Chicago, Ill.

Swan, Frederick, 1518 Otis Building, Chicago, Ill.

Tuttle, Mrs. George T., McLean Hospital, Waverley, Mass.

Upton, Ruth M., 2920 Pine Grove Ave., Chicago, Ill.

Wallace, Anna, M. D., Assistant Physician Chicago State Hospital, Dunning, Ill.

Webb, Belle Boynton, Rochester, Minn.

White, C. E., M. D., Superintendent Weston State Hospital, Weston, W. Va.

Wilde, Walter J., Member Board of Administration Milwaukee County, 413 25th Ave., Milwaukee, Wis.

Yates, F. A., 208 W. Monroe St., Chicago, Ill.

Yoakum, Clarence S., M. D., Major Sanitary Corps N. A., Office of Surgeon General, Washington, D. C.

Young, G. A., M. D., Professor Nervous and Mental Diseases, University Hospital, Omaha, Neb.

Yule, Mrs. Lorne W., Roanoke, Va.

#### AFTERNOON SESSION.

The meeting was called to order by the President at 2.30 p. m.

THE PRESIDENT.—The following cablegram has been received by Dr. Wagner, from Dr. Thomas W. Salmon, who is now in France.

(dated) France.

Doctor Charles G. Wagner,

Binghamton, N. Y.

Send greetings and wishes for successful meeting from members Association in American Expeditionary Force, who in field, camp and hospital are applying best standards American psychiatry for welfare our soldiers.

(Signed) Salmon.

DR. C. B. BURR.—I move that a cablegram in reply be sent to Dr. Salmon.

Motion seconded and unanimously carried.

THE PRESIDENT.—The first paper on the program for the afternoon is "Simulation—Not an Adequate Diagnosis," by Dr. William A. White of Washington, D. C. I believe Dr. White is not present.

Motion made and unanimously carried that this paper be read by title.

THE PRESIDENT.—The second paper is "Studies in Paraphrenia," by Dr. A. A. Brill of New York City.

Dr. Brill then read his paper.

THE PRESIDENT.—If there is no discussion of Dr. Brill's paper we will proceed to the next paper, which is by Dr. L. Pierce Clark. Dr. Clark has sent a message that he is unable to attend the meeting, but that his paper will be read by Dr. Spaulding.

Dr. Clark's paper entitled "The Psychoanalytic Treatment of Retarded Depressions," was read by Dr. Spaulding.

THE PRESIDENT.—It has been suggested that discussion on these psychoanalytic papers be deferred until the papers are all read; if this meets with your approval we will pass on to the next paper.

The following papers were then read:

"The Occurrence of Schizophrenic Characteristics in Affective Disorders," by Phyllis Greenacre, M. D., Baltimore, Md.; "What Shall the Attitude of Psychiatrists be Toward Psychoanalysis in the Treatment of Dementia Præcox?" by Michael Osnato, M. D., New York City. (Dr. Osnato was detained on military duty and his paper was read by title.) "Interpretation of the Functional Nervous Diseases at the Physico-Chemical Level," by D. W. Roberts, M. D., Milwaukee, Wis.

The above papers were discussed by Drs. Southard, Hill and Dewey.

THE PRESIDENT.—As you probably know, many of the members are anxious to go home Thursday night or early Friday morning. If we can we mean to have the papers assigned for Friday on the program, read during the next three days. Dr. Dewey is down for a paper on Friday and he has kindly consented to read it this afternoon.

Dr. Dewey read his paper entitled "Remarks upon the Nursing Problem as Related to Psychopathic Patients." Discussed by Drs. Brush, Southard, Burr, Gorst and Dr. Dewey in closing.

THE PRESIDENT.—There are two other papers scheduled for Friday morning:

"Efficiency Study of Accidents in State Hospitals," by Myrtelle M. Canavan, M. D., Boston, Mass., and

"An Analysis of the Accuracy of Psychopathic Hospital Diagnosis," by Lawson G. Lowrey, M. D., Boston, Mass.

Neither Dr. Canavan nor Dr. Lowrey are present, and Dr. Southard, who is familiar with the subjects presented in these papers, will give us an abstract of them.

Dr. Southard gave a brief abstract of the above papers.

THE PRESIDENT.—If there is no discussion of these papers, after I have made an announcement or two we shall adjourn until eight o'clock this evening.

None of the auditors are present at this meeting, and as certain matters have been referred to them and the books must be audited, I will appoint as auditors for this meeting, Dr. English of Ontario, and Dr. Laughlin of Indiana.

Adjournment.

#### EVENING SESSION.

The Association was called to order by the President at 8 o'clock.

THE PRESIDENT.—I am pleased to announce that we are to have a few recreative moments this evening. I will ask Dr. Burr to introduce the speaker.

DR. BURR.—*Mr. President and Members of the Association, Ladies and Gentlemen:* When that unspeakable brute, the Prussian Kaiser, that sanctimonious crocodile, drew his hideous and slimy length over Belgium, a good many people—not so many as should, but a good many people—sat up, rubbed their eyes and began to take notice. Among them was an American woman who was at that time living in Brussels; she wanted to see; she was under the same delusion about Boche kindness and decency as a great many people; she wished to be shown. She *did* see the invasion of Belgium, at all events, that portion when the invading army passed through Brussels. She has a wonderful message. I have heard her speak many times; we have become greatly attached to her in Flint, where I live. She is our adopted daughter. She has helped us in the Liberty Bond and other campaigns, and you will have no doubt after hearing her speak that it was easy to go "over the top" so far that the top looked like a depression. She comes from Washington, her present home. She was living at the time the war broke out—in Belgium. She has two sons; one was with the C. R. B. in Belgium and is now with the American Army in France; another son will soon be in the war—the first of July. I said she lived in Washington; she is a citizen of the world, almost all the world, one part only excepted—that part toward which no decent person now admits any sentimental feeling.

Mrs. Clarke, before you speak, I would like to call your attention to the fact that this morning a service flag was presented by the citizens of Chicago to our Association; it bears 93 stars. I would like also to tell you that this is the first medical organization, national organization at least, that adopted resolutions in favor of universal military training; those resolutions were adopted in 1916, at New Orleans.

Mr. President, Ladies and Gentlemen, I feel it a great privilege, a very distinguished honor to present Mrs. Basil Clarke to this Association.

Mrs. Clarke spoke very interestingly of the conditions existing in Belgium and gave a very vivid description of the entrance of the German army into Brussels and of their awful atrocities; she also recited many of her own experiences before she left Belgium, which were received with prolonged applause.

THE PRESIDENT.—Mrs. Clarke, words would spoil the effect of your address if we were to thank you for this graphic story; it will never be forgotten.

We will proceed with the reading of papers scheduled for the evening program.

The following papers were read:

"Moving Picture Studies of Stereotypic Muscular Movements in Dementia Præcox and of the Movements in Huntington Chorea," by A. W. Hoisholt, M. D., Napa, Cal.; "Psychiatric Aims in the Field of Criminology," by Bernard Glueck, M. D., Ossining, N. Y.; "Studies in Orthopsychics," by Herman M. Adler, M. D., Chicago, Ill.

THE PRESIDENT.—The hour is late, and if you approve we will adjourn now and have the remaining papers in the morning, together with any discussion that may arise from the series of the evening.

On motion the meeting adjourned.

WEDNESDAY, JUNE 5, 1918, 10.00 A. M.

THE PRESIDENT.—The first order of business for the morning is the report of the Council.

#### REPORT OF THE COUNCIL, JUNE 5, 1918.

The Council recommends the election of the following named physicians to associate membership:

C. Arkebauer, M. D., Little Rock, Ark.; Samuel N. Clark, M. D., Chicago, Ill.; Raymond F. Dowell, M. D., Elgin, Ill.; Blanche W. Horner, M. D., Rochester, Minn.; James J. Walsh, M. D., Elgin, Ill.

The Council recommends the transfer of the following named associate members to the active class:

Solomon C. Fuller, M. D., Westborough, Mass., and Harold I. Gosline, M. D., Trenton, N. J.

The Council has received the following applications for active membership. In accordance with the constitution final consideration of these will be deferred until next year:

William C. Harriman, M. D., Orillia, Ont.; P. C. Oberndorf, M. D., New York City; George Alexander Young, M. D., Omaha, Neb.

The Council recommends that the dues for the ensuing year be increased to \$7.00 for active members, and \$3.00 for associate members.

Respectfully submitted,

H. C. EYMAN, *Secretary*.

DR. SANGER BROWN.—I move the recommendations of the Council be accepted and adopted.

Which motion was duly seconded and carried.

THE PRESIDENT.—The next order of business is the election of members proposed yesterday. The Secretary will read the names, and pass the ballots.

(This list will be found in the first report of the Council.)

DR. WOODSON.—I move that the rules be suspended and the Secretary be authorized to cast the ballot of the Association electing these physicians to membership.

Which motion was duly seconded and unanimously prevailed.

THE PRESIDENT.—Is there any unfinished business? If not, we will hear the report of the Nominating Committee.

DR. PILGRIM.—Your committee appointed to nominate the officers for the current year would respectfully recommend the election of the following gentlemen:

For President, Elmer E. Southard, M. D., Boston, Mass.

For Vice-President, Henry C. Eyman, M. D., Massillon, Ohio.

For Secretary-Treasurer, Arthur P. Herring, M. D., Baltimore, Md.

For Councilor for one year to fill the place of Dr. Thomas C. Biddle, deceased, M. L. Perry, M. D., Topeka, Kan.

For Councilors for three years: James V. Anglin, M. D., St. John, N. B.; Britton D. Evans, M. D., Morris Plains, N. J.; H. W. Mitchell, M. D., Warren, Pa.; Clarence Pierson, M. D., Jackson, La.

For Auditor for three years: Joseph C. Clark, M. D., Sykesville, Md.

(Signed) T. J. W. BURGESS, *Chairman*,

B. M. CAPLES,

CHAS. W. PILGRIM.

DR. S. E. SMITH.—I move that the report of the Nominating Committee be accepted and adopted, and that the President be instructed to cast the ballot of the Association for the election of these officers.

This motion was seconded by Dr. Woodson, and unanimously carried, and the officers were declared elected.

THE PRESIDENT.—The report of the auditors will be deferred until a later day.

As the committee on resolutions I would name Dr. Charles G. Wagner of New York, Dr. S. E. Smith of Indiana, and Dr. W. M. English of Ontario.

The papers left over from last night will be presented at this time.

The following papers were read:

"Some Emotional Episodes Among Psychopathic Delinquent Women," by Edith R. Spaulding, M. D., Bedford Hills, N. Y.; "The Mental Deficiency Survey of Kentucky, 1917," by Thomas H. Haines, M. D., Columbus, Ohio.

THE PRESIDENT.—There is now opportunity for brief discussion of the series begun last night and completed this morning on Delinquency.

These papers were discussed by Dr. Southard.

THE PRESIDENT.—The regular program for the morning will now be continued. I will call on Dr. Brush for his paper entitled "Hospital Organization and Management."

DR. S. E. SMITH.—Dr. Brush has been called out and has asked me to make excuse for him and to say that he will read his paper later.

THE PRESIDENT.—We will go on to the next paper, entitled "The Work of the New York Hospital Development Commission," by Dr. Charles W. Pilgrim, Albany, N. Y.

Dr. Pilgrim stated that owing to sickness he had been unable to prepare a complete paper upon "The Work of the New York Hospital Development Commission," and in lieu of that he gave the following brief extemporaneous account of its origin and progress:

The New York State Hospital Development Commission was organized in 1917 by an act of the Legislature, known as Act No. 238. The personnel of this Commission is made up as follows: First, there is the Chairman of the Senate Finance Committee, the Chairman of the Ways and Means Committee of the Assembly, and a minority member of one or the other of these bodies to be selected by his associates; then there is the Chairman of the State Hospital Commission, the State Architect, the State Engineer, and two members who are not connected with the state hospital service, appointed by the Governor. The act organizing this Commission made several definite recommendations and outlined the work which was expected of it.

The first thing that we were called upon to do was to take a census of the patients in the hospitals of the state, and to estimate the probable number that would be under state care at the end of ten years, as it is the idea that this Commission shall be perpetuated and shall exist during a period of 10 years, and that annual appropriations shall be made covering the needs of the different hospitals for their proper efficiency and development, and that these expenditures shall be divided as nearly as possible in equal amounts over this period of ten years. The survey showed that in all probability this would involve an expenditure of \$20,000,000 at the rate of \$2,000,000 each year.

We were then directed to measure up and arrange upon some scientific and accurate method of calculating the capacity of the various hospitals. This was done in every hospital in the state, and is described in the preliminary report, an article entitled "The Planning of a Hospital for the Insane." We took as our working basis 50 square feet per patient in dormitories, and 40 to 50 in day-rooms, 14 to 16 in dining-rooms, and each single room the size varying from 7 x 9 to 10 x 12, was counted as space for but one bed. In this way we arrived at the capacity of each hospital and certified what the proper capacity should be. We decided among other things, that single rooms should preferably contain about 80 square feet of space, with not more than one patient in a room, and in order to prevent two patients being placed in one room we have recommended that single rooms shall be about 7' x 11' or 8' x 10'.

The Commission visited all the hospitals in New York state and many in other states, including Massachusetts, and also the Whitby institution in Canada. The members set about their work with a determination to learn everything that it was possible to learn which would be of benefit in developing the hospital system of the state of New York.

There was one duty which the Commission was called upon to perform which at first promised to be the source of a great deal of trouble; this was to consider the future policy of the state for the care of the insane—whether it was to be hospital or custodial care. This question was gone into very thoroughly, and I am very glad to state that the Commission unanimously reported against custodial care.

As a preliminary report I would say that this Commission has succeeded in getting appropriations for making certain additions to the different hospitals of the state in order to bring each hospital up to its maximum efficiency and to make each hospital as nearly perfect in arrangement as possible. Besides getting money for additions to several of the hospitals, we succeeded in getting appropriations for the plans for a psychopathic hospital in the City of New York, and for practically the rebuilding of the Brooklyn State Hospital; the building of a new institution at Creedmoor and another one at Marcy in connection with the Utica State Hospital; and also a small appropriation for the expenses necessary for the selection of a site for a new hospital in the neighborhood of New York to relieve the overcrowding of the metropolitan district. In all we succeeded in securing appropriations amounting to something more than \$2,000,000, and we expect to go on at this rate during the next 10 years.

In order to show you the attitude of this Commission, which was largely made up of legislators and other state officials, and only two physicians, I would like to read a few paragraphs from the preliminary report:

"The Commission desires in this report to do justice to the management of the state institutions visited. It is a pity that every tax-payer in the state cannot visit these great institutions and see how his money is being expended. We believe that he would return from such an inspection with greater pride in his state and with a lively sense of gratitude toward those who are spending their lives in an endeavor to improve the mental health and to alleviate the sufferings of the helpless wards of the state. The defects in our system and in our individual institutions are not due either to our very efficient Hospital Commission, or to the management of the separate institutions. Rather are they due to an unawakened public conscience, a lack of knowledge both in the medical profession and in the State Legislature, and a lack of system in our method of making appropriations.

"Every insane hospital in the state is spotlessly clean and well kept. In every hospital the facilities at hand are used to the utmost and everywhere the patients are treated with humanity, kindness and understanding. But it is impossible to accomplish cures where a condition of overcrowding exists to such an extent that new arrivals and chronics must be cared for in the same wards, and where the day-room space is filled with beds. For such conditions neither the Hospital Commission nor the superintendents are in any way responsible. The responsibility rests with a so-called economy (unwise, inhumane and ignorant, for which a better name is parsimony) in needed appropriations. But even under these adverse conditions the superintendents have managed to keep up their courage and to a large extent their enthusiasm, and have done the best they could and have given the best that was in them to humanity and the state."

When we can get a legislative investigating body to write in such a sympathetic way in regard to the care of the insane and the work that is being done for them, I feel that we have reason to hope that New York during the next 10 years will achieve results which are most to be desired.

The following papers were read:

"The Organization of the State Hospital Service in Illinois," by H. Douglas Singer, M. D., Kankakee, Ill. Discussed by Dr. Brush and Dr. Singer in closing.

"The Rehabilitation in the Community of Patients Paroled from Institutions for the Insane," by Samuel N. Clark, M. D., Chicago, Ill. (Read by title.)

THE PRESIDENT.—To expedite the disposal of the program I will ask Dr. Southard to give us an abstract of Dr. Solomon's paper, who is not present.



Dr. Southard gave a brief abstract of the paper entitled: "Syphillis in Mental Hospitals and the Community," by Harry C. Solomon, M. D., 1st Lieut. M. R. C. Discussed by Drs. Mitchell, Brush, Gorst and Pierson.

On motion the meeting adjourned.

# AFTERNOON SESSION.

THE PRESIDENT.—The Association will please come to order.

Dr. Southard has several resolutions to offer.

DR. SOUTHARD.—I would offer the following resolution:

*Resolved*, That a War Work Committee of seven members be established.

DR. BRUSH.—I move that the committee mentioned in the resolution be appointed.

Motion seconded.

DR. WOODSON.—What is the real object of this committee, and would it be an expense to this Association?

DR. SOUTHARD.—It is not the idea that any expense be incurred. As to the object, it would take an hour or two to explain the details of this work. Of course, it is all done through the National Committee for Mental Hygiene, which regularly has a little money, and covers the work of reconstruction camps or units.

DR. WOODSON.—The work of the committee consisting of one from each state has done, I think, very commendable work. I have been called upon repeatedly through the committee to mention names of men who would be suitable and have recommended some sent in and a number have been accepted and I understand are making good; some have gone abroad. I think this work is a very good one; I think there is no reason why that committee should not be continued or a new committee appointed.

DR. BRUSH.—I think the Neuro-Psychiatric Division of the Surgeon General's office has been quite fortunate in having the advice and co-operation of Dr. Williams of the National Committee for Mental Hygiene; in some instances it has not had advice or co-operation from the committee appointed by this Association last year and in some instances it has not asked for it. With a small committee regularly within reach, working together, consulting with different ones they can do all the work that this widely extended committee does, which uses no standard as to the kind of men it will recommend, and I think will do very much better work than this very large committee.

Dr. Brush's motion was carried unanimously.

DR. SOUTHARD.—My second resolution is the following:

WHEREAS, A majority of the members of two committees, named below, and all their members who have replied to a circular letter, feel that the two committees should hereafter be fused into one;

*Resolved*, That the Committee on Scientific Exhibit and the Committee on Pathological Investigation be fused into one committee, viz., the Committee on Pathological Investigation.

I move that this resolution be adopted.

Motion seconded and carried.

DR. SOUTHARD.—Resolution No. 3 is as follows:

WHEREAS, The financial authorities of the several states and the United States have had at different times a very various policy in regard to delegation of representatives and the payment of their expenses to the annual meetings of the American Medico-Psychological Association;

WHEREAS, The failures so to appoint delegates and defray expenses are sometimes due to the lack of a just appreciation of the Association's work and sometimes to a spirit of pseudo-economy;

*Resolved*, That the American Medico-Psychological Association hereby expresses its deliberate opinion that (a) every state institution and incorporated institution for the insane or the mentally sick; (b) every state board of control or supervision of these classes, and (c) every federal institution or unit for the care of these classes ought to be represented by a delegate or delegates, whose expenses should be defrayed by the several said State or Federal Governments or by the Managing Boards of Incorporated Institutions;

*Resolved*, That a brief brochure or pamphlet be prepared by a temporary committee, stating the general and special reasons why said delegations and defrayals are in the best interests of State and Federal Governments, and of the care, treatment, and prevention of mental diseases and defect, and

*Resolved*, That printed copies of said brochure or pamphlet, together with these resolutions, be made available for transmission where desirable to the above-mentioned financial or controlling authorities.

DR. SOUTHARD.—I move that these resolutions be adopted.

Motion seconded and carried.

DR. BRUSH.—The Council has requested me to present the following resolution:

WHEREAS, The members of the American Medico-Psychological Association recognize the importance, in the advance of medical science, of the Army Medical Museum and the very pressing necessity of enlarging and improving its facilities;

*Resolved*, That this Association urges upon Congress, and the Medical Department of the army that steps be inaugurated at once to that end.

*Resolved*, That the individual members of the Association be requested to bring this matter to the attention of their local representatives in Congress, urging them to support any measure introduced in Congress by the War Department through the Surgeon General's office looking to the enlargement and improvement of the Army Medical Museum and its future liberal financial support.

*Resolved*, That a copy of the foregoing be transmitted to Major R. W. Shufeldt, of the Medical Corps of the United States Army.

I move that these resolutions be adopted.

Which motion was duly seconded and carried.

THE PRESIDENT.—We will now hear the report of the Council.

#### REPORT OF THE COUNCIL, JUNE 5, 1918.

The Council recommends the election of the following named physicians to associate membership:

Roderick B. Dexter, M. D., Boston, Mass., and F. N. Maginnis, M. D., Aurora, Ill.

The Council has received the following applications for active membership. In accordance with the constitution final consideration of these will be deferred until next year:

D. C. Main, M. D., Alfred, N. Y.; C. Renz, M. D., San Francisco, Cal.; Charles C. Rowley, M. D., Grand Rapids, Wis.

(Signed) H. C. EYMAN, *Secretary*.

On motion duly seconded the report of the Council was accepted and adopted.

THE PRESIDENT.—We will now proceed to the reading of the papers on the program for the afternoon.

The following papers were read:

“Personality Study in Psychiatric Cases,” by G. S. Amsden, M. D., White Plains, N. Y.; “A Clinical Summary of 106 Cases of Mental Disorder of Unknown Etiology Arising in the Fifth and Sixth Decades,” by E. T. Gibson, M. D., Middletown, Conn. (Read by title.) “Recent American Classification of Mental Disease,” by E. E. Southard, M. D., Boston, Mass. Discussed by Dr. Abbott and Dr. Southard in closing.

THE PRESIDENT.—Motion to adjourn will be in order. With your consent we will adjourn until this evening at 8.30 in this room.

#### EVENING SESSION

THE PRESIDENT.—Ladies and Gentlemen, we have with us this evening Professor Paul Shorey, of the University of Chicago. For some years past it has been the custom of the Association to devote an evening to the pleasure of hearing an address from some one not connected with our organization. Professor Shorey has kindly consented to give the address this evening.

Professor Shorey delivered his address, “Insanity and Literature,” which was received with continuous applause.

DR. HILL.--Mr. President, after listening for several days to the various questions of psychiatry, hearing the matter discussed from every standpoint, learning new phases and new terms, viewing it from all angles and elevations, I am sure you all feel as I do that we have been highly entertained with the learned philologist's address this evening. I therefore move, Mr. President, that we extend to the Professor a vote of thanks for his presence and his delightful address on this occasion.

THE PRESIDENT.—All who agree with Dr. Hill in regard to this vote of thanks, and agree with Dr. Hill's sentiments, kindly signify by standing. Professor, you have the unanimous thanks of this Association.

Adjournment.

THURSDAY JUNE 6, 1918, 10.00 A. M.

THE PRESIDENT.—The meeting will please come to order. We will first have the Council report.

REPORT OF COUNCIL, JUNE 6, 1918.

The Council recommends the election of Roger C. Swint, M. D., Milledgeville, Ga., as an associate member of the Association.

The Council has received the applications of the following named physicians for active membership. In accordance with the constitution, final consideration of these names will be deferred until next year:

Lieutenant-Colonel Pearce Bailey, M. D., Medical Corps, N. A., and H. S. Hulbert, M. D., of the Great Lakes Naval Training Station, Lake Bluff, Ill.

The Council wishes to express most sincere appreciation for the entertainment of the Association on Wednesday at the Great Lakes Naval Training Station, and extends hearty thanks to Captain Moffatt for his invitation, and to Dr. Hulbert for the extremely interesting and instructive demonstration of the work of the Psychiatric Unit.

Respectfully submitted,

H. C. EYMAN, *Secretary*.

On motion of Dr. Woodson, duly seconded, the report of the Council was accepted and adopted.

THE PRESIDENT.—We will now proceed to the election of associate members presented yesterday. I will ask the Secretary to read the names.

The following names were read:

C. Arkebauer, M. D., Little Rock, Ark.; Samuel N. Clark, M. D., Chicago, Ill.; Raymond F. Dowell, M. D., Elgin, Ill.; Blanche W. Horner, M. D., Rochester, Minn.; James J. Walsh, M. D., Elgin, Ill.; Solomon C. Fuller, M. D., Westborough, Mass., and Harold I. Gosline, M. D., Trenton, N. J., for transfer from associate to active membership.

On motion, duly seconded, the Secretary was authorized to cast the ballot of the Association electing the above-named physicians to associate membership, and transferring Drs. Fuller and Gosline from associate to active membership in the Association.

THE PRESIDENT.—As we expect to complete the program to-day we will combine this morning, afternoon and Friday as printed. The program calls for report of the Council on time and place of next meeting. This report was presented at a previous session and adopted by the Association, the place selected being Philadelphia.

DR. BURR.—I move that the Association concur in the expression of the Council and adopt its suggestion by a rising vote of thanks to Captain Moffatt and Dr. Hulbert.

Motion seconded and carried.

DR. SOUTHARD.—There are two suggestions I would like to make; one is that the name of the committee on diversional occupation be changed to read "Committee on Occupational Therapy." The point is that it will include war work and all things that are not strictly diversional, but are economic; these I think should be included. No one has raised a dissenting voice to this idea of changing the title from diversional occupation to occupational therapy. I therefore make this resolution in the form of a motion.

Which motion was duly seconded and carried.

DR. SOUTHARD.—The second is the question raised by Dr. Hulbert's work yesterday. I move that the letter of the constitution be changed so that physicians of extraordinary merit may be received directly into active membership. I make such a motion.

DR. WOODSON.—I move that Dr. Southard be requested to put that in form so that it may lay over until another year.

THE PRESIDENT.—We are willing to waive the clause in the constitution which states that this shall be done at the first session of the second day.

Motion carried.

Dr. Southard offered the following resolution:

*Resolved*, That the following change in the constitution be placed on the docket for consideration at the annual meeting of 1919, viz.:

Insert after the phrase "Active membership," Article V, line 33, the following sentence:

"Candidates for active membership who are of extraordinary merit may be elected at the same meeting at which their names are proposed, provided that six names of active members representing six different states are affixed to the application blank."

DR. ORTON.—I wish to call the attention of the Association to the fact that we have elected a man as Secretary who is in active service of the

United States. I think the work of the Secretary of this Association is in itself a considerable task and work that could not be done by a man whose hands are more than full. I think we are doing rather an injustice to Dr. Herring in asking him to take over the work of the secretaryship in addition to his own work. The suggestion I would make is that either the matter be turned over to the hands of the Chairman of the Nominating Committee, or that the Council reconsider the election of Dr. Herring with the idea of relieving him of the duties and placing the work in the hands of some one who will be able to devote more time to the work of the Association.

DR. WAGNER.—I would like to add that from personal knowledge of the work of the Secretary I am able to state that the position of the last speaker is very well taken indeed. The Association now numbers more than 900 members; the work of the Secretary-Treasurer has increased enormously in the last few years; the routine procedure is complicated and therefore it is important that the incoming Secretary should be here at this meeting in order to get a grasp of the details. As he has not been able to be present I foresee a good deal of trouble in organizing the next meeting. Those who have occupied the office of Secretary appreciate more than anybody else the need of a thorough knowledge of the routine procedure of this Association in the preparation of the program and the details for a meeting of this kind. I think we should if possible take steps to guard against failure of the meeting next year, which I fear might occur if Dr. Herring is occupied with his military duties the larger part of his time. I think it is due Dr. Herring that something be done to guard against trouble of that kind.

DR. BRUSH.—I concur in what Dr. Wagner says. The constitution provides that officers shall take their places immediately on election. The Secretary is not here to take his place.

DR. EYMAN.—I can bear out what has been said about the duties of the Secretary, and I am sure I would not have been able to do the work without instruction from Dr. Wagner, and without any instruction I do not believe Dr. Herring will be able to do it.

DR. WOODSON.—It is a regrettable affair that this matter has been overlooked, and I would make the motion that the Association authorize the Council to nominate Dr. Wagner to fill the office of Secretary during the time of the war.

DR. WAGNER.—While I thank Dr. Woodson for the compliment he implies, I beg to decline for the simple reason that I have served as Secretary for six years and cannot undertake further service. It is a very laborious task to perform the duties of the Secretary; I have gotten out of the routine of it, and it would be a hard matter for me to take it up again, and, besides, I am getting old. We want a younger man with energy, a man full of vigor and "pep" who will put his heart and soul into the work of the Association; I know such a man—he sits near me on my right, Dr. Mitchell.

DR. WOODSON.—I withdraw my motion.

DR. BURR.—I heartily accept Dr. Wagner's motion.

DR. WAGNER.—I do not know that I could offer a motion until some action is taken to clear the way. As the Association has elected Dr. Herring Secretary, the difficulties that appear in the way of his officiating in that capacity would seem to warrant the Association in taking some action to clear the way.

DR. ENGLISH.—I would move that the action of yesterday regarding the report of the Nominating Committee be rescinded in so far as it refers to the Secretary.

Motion seconded.

THE PRESIDENT.—All in favor of Dr. English's motion please rise.

Carried.

DR. BURR.—I move that Dr. Woodson's amendment be accepted and the name of Dr. Mitchell be substituted in place of Dr. Wagner.

THE PRESIDENT.—I understand Dr. Herring has been consulted and has consented to accept the office of Secretary. If he is willing to do the work it puts him in a rather awkward position.

DR. WOODSON.—If it be in order, I suggest that you appoint a committee from the Council to confer with Dr. Herring and if he can do the work, that he be retained; and if not, authorize the Council to fill the office.

Motion seconded.

DR. ORTON.—I move the name of Dr. Mitchell be placed before the Association as the new Secretary. If it is necessary for the names of officers to go through a Nominating Committee, I move that the Nominating Committee be instructed to place the name of Dr. H. W. Mitchell before the society for the office of Secretary.

DR. J. C. MITCHELL.—I cannot see how we can instruct the Council to present a certain name before the society when the Nominating Committee has already made its report and it has been accepted by the Association.

DR. BURR.—Article VIII of the Constitution provides that: "All the officers and councilors shall enter upon their duties immediately after their election, excepting the President and Vice-President." How do you get around this? We have no Secretary at this meeting.

DR. BRUSH.—The Association has proven competent to elect a Secretary without referring it back to the Nominating Committee again. We have no Secretary as we have rescinded the election made yesterday and it is very important to elect a Secretary.

DR. WOODSON.—Dr. Burr's reading of the Constitution covers the ground, and I would suggest that the Nominating Committee retire at once and let us fill this position. I move, in view of the fact that the Secretary is

not here to assume the duties of the office, and as the Constitution demands such presence, that the Nominating Committee be informed as to the desire of this Association, and that Dr. Mitchell be named to fill that office.

Which motion was duly seconded and unanimously prevailed.

THE PRESIDENT.—I will name Dr. Bancroft to take the place on the Nominating Committee of Dr. Pilgrim, who has gone home.

We will now have the report of the Auditors.

CHICAGO, June 6, 1918.

*To the American Medico-Psychological Association:*

We, your *pro tem.* auditors, beg to report that we have carefully examined the books and vouchers of the Secretary-Treasurer, and the editor of the AMERICAN JOURNAL OF INSANITY, and would state that in the absence of the "balance statement" of the Mutual Building and Investment Company, of Cleveland, O., one of the depositories of the Association funds, we are unable to fully review the statement presented, but it appears that there has been a slight clerical error amounting to \$10 in the making up of the balance on hand to our credit.

In the pass-book of the First National Bank of Massillon, Ohio, no entry appears of a sum of interest amounting to Four 30/100 dollars, though a deposit slip shows that such a sum was entered on the monthly statement and claimed as a receipt by the Secretary-Treasurer. Otherwise the books have been accurately and neatly kept. We would suggest that these items be adjusted before the books are handed over to his successor.

The vouchers, etc., of the editors of the JOURNAL we found accurately and neatly kept.

All of which is respectfully submitted,

(Signed) W. M. ENGLISH,  
C. E. LAUGHLIN,  
*Auditors.*

On motion, the report of the Auditors was accepted and adopted.

THE PRESIDENT.—I will call for the report of the Committee on Resolutions.

#### REPORT OF COMMITTEE ON RESOLUTIONS, JUNE 6, 1918.

Mr. President, your committee, charged with the agreeable duty of recording our appreciation of the courtesies the members of our Association have enjoyed during its seventy-fourth annual meeting, held in the great city of Chicago—the "Queen of the North and the West"—feels at a loss to find suitable words to adequately express the Association's sentiments.

To the Committee of Arrangements our thanks are due and given in full measure for its highly successful efforts to provide social entertainment



and pleasing diversions not only agreeable in character, but educational and profitable as well.

To the Committee on Program, on Exhibits and Diversional Occupation, and to our efficient and tireless Secretary credit is due and freely given for a most successful and satisfactory meeting, and to our President we would make grateful acknowledgment and express our unqualified appreciation and approval of his scholarly, patriotic and inspiring address.

We would also express our thanks and appreciation to the officials and citizens of Chicago for the splendid service flag presented to our Association in commemoration of the patriotic members now in the military or naval service of our country, and to the management of the Hotel LaSalle for all the courtesies extended to us during our stay within its hospitable portals.

CHARLES G. WAGNER, *Chairman*,  
SAMUEL E. SMITH,  
W. M. ENGLISH,  
*Committee on Resolutions.*

DR. BRUSH.—I move the adoption of the report.

Motion seconded and carried.

THE PRESIDENT.—I will call for the report of the Committee on Statistics.

REPORT OF THE COMMITTEE ON STATISTICS.

*To the American Medico-Psychological Association:*

Your Committee on Statistics begs to submit the following report for the year ending June 1, 1918:

In accordance with the recommendations made by the former Committee on Statistics in its report to the Association in May, 1917, this committee has endeavored to secure the adoption of the Association's classification by state and federal authorities and the introduction of a uniform system of reports in the state hospitals for the treatment of mental diseases throughout the country.

Owing to his active leadership in the psychiatric work in the army, Dr. Salmon was not able to act as chairman of the committee nor to attend its meetings. He promoted the committee's work most effectually, however, by securing from the Rockefeller Foundation a special gift for the National Committee for Mental Hygiene to defray the expenses of the introduction of the system of uniform statistics of mental diseases during the present year. Psychiatric work in the army also prevented Major E. Stanley Abbot from taking part in the deliberations of the committee.

The committee met in New York City on February 7, 1918, and outlined a definite plan of procedure. As the National Committee for Mental Hygiene had the necessary funds at its disposal and had established a Bureau of Statistics, it was thought wise for your Committee on Statistics to become an advisory committee to such Bureau and to have the work of introducing the new system and of collecting statistics from the institutions

carried out by the Bureau. A letter explaining the proposed classification was sent on April 15, 1918, to every state hospital and to the central board of administration in each state that had not already signified its intention of adopting the new system. Replies to this letter are very encouraging. Of the 156 state hospitals, 83 have already adopted the Association's plan, 34 will adopt it and 24 others favor it, and will probably adopt it as soon as authority therefor is obtained. Two hospitals have reported unfavorably. Altogether 138 state hospitals have signified their willingness to co-operate and practically no opposition to the plan has arisen. The states fully committed to the uniform system at the time of the writing of this report were Alabama, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia and Wyoming. It is probable that favorable action will soon be taken in other states.

The Association's classification has been adopted by the Surgeon General of the Army and is being used in diagnosing mental disease at the several cantonments of the National Guard and National Army.

The 18 forms for statistical tables adopted by the Association last year, are now being printed and will be distributed gratis by the Bureau of Statistics of the National Committee for Mental Hygiene. The Bureau in co-operation with this committee is also preparing a statistical manual for the use of hospitals for the insane. This manual will serve as a guide for the preparation of statistical data and its use will be essential to the successful operation of the system.

In this connection the committee would request authority to incorporate in the manual certain minor changes in the classification which seem desirable at this time. It will undoubtedly be necessary to propose for the approval of the Association in future reports other changes that experience may show to be advisable.

It is urged that the members of the Association give their hearty support to this movement for better statistics during the coming year so that the work so auspiciously begun may soon be brought to a high state of perfection.

(Signed) ALBERT M. BARRETT,  
GEORGE H. KIRBY,  
JAMES V. MAY,  
OWEN COPP,  
A. MEYER,  
*Committee on Statistics.*

DR. ENGLISH.—I move that the report be accepted.

Motion seconded and adopted.

THE PRESIDENT.—We will complete our program with this evening's session, when we will have an address by Dr. Ray Lyman Wilbur. What

I would like would be for all to come to this evening's session and bring their friends. I think it would be proper for Dr. Mitchell, chairman of the Program Committee, to explain who Dr. Wilbur is.

Dr. Mitchell spoke briefly of the work of Dr. Wilbur, how he had assisted Mr. Herbert Hoover in the organization of the United States Food Administration and of his work in Washington at the present time, in connection with the Food Administration.

**THE PRESIDENT.**—We will proceed to the reading of papers.

The following papers were read:

"Different Anatomical Findings in Three Cases of Infectious Delirium," by Samuel T. Orton, M. D., Philadelphia, Pa.; "Syphilis of the Nervous System," by Benjamin F. Williams, M. D., Lincoln, Neb.; "The Work of Psychiatrists in Military Camps," by E. Stanley Abbot, Major, M. R. C. Discussed by Drs. Burr, Pierson and Woodson.

**DR. CAPLES.**—Mr. President, through a misunderstanding as to the constitution providing that the Secretary and other officers shall be present and enter upon their duties immediately after election, the name of Dr. Herring was presented. The Nominating Committee has decided to withdraw that name and to present the name of Dr. H. W. Mitchell of Warren, Pa. Dr. Mitchell has been long connected with this Association and is entitled to the office of Secretary.

**THE PRESIDENT.**—What is your pleasure, gentlemen?

**DR. J. C. MITCHELL.**—I move that the report of the Nominating Committee be received and adopted, and that the Secretary be instructed to cast the ballot for the election of Dr. Mitchell.

Motion seconded and unanimously carried.

The Secretary announced that he had cast the ballot for the incoming secretary.

**DR. BURR.**—I move that Dr. Wagner be requested to induct Dr. Mitchell into office.

Dr. Wagner then escorted Dr. Mitchell to the platform.

**THE PRESIDENT.**—The meeting is adjourned until 2.30 this afternoon.

#### AFTERNOON SESSION.

**THE PRESIDENT.**—The first order of business is the election of members whose names have already been presented to the Association. I will ask the Secretary to read them.

The following names were read:

Roderick B. Dexter, M. D., Boston, Mass.; F. W. Maginnis, M. D., Aurora, Ill.; Roger C. Swint, M. D., Milledgeville, Ga.

On motion the Secretary was instructed to cast a ballot electing the above-named physicians to associate membership.

The Secretary announced that the ballot had been cast as directed.

The following papers were read:

"Food and Its Service at the Provincial Hospitals," by J. C. Mitchell, M. D., Brockville, Ont.; "The Community Mental Health Movement and Its Probable Dependence for Success on a Higher State Hospital Standard for Ward Employees," by Sidney D. Wilgus, M. D., Rockford, Ill. Discussed by Drs. Gorst, Sanger Brown, Woodson, Kilbourne, Hotchkiss and Wilgus in closing.

DR. GORST.—I desire to offer the following resolution:

*Resolved*, That a committee be appointed by this Association whose duty it shall be to investigate the methods of nursing and attendant care in both acute and chronic cases of the insane practiced in the United States and Canada, and to make its report, with recommendations, at the next annual meeting.

I move the adoption of the resolution.

This motion was seconded by Dr. Sanger Brown.

THE PRESIDENT.—All in favor of the motion that a committee of five be appointed to investigate the nursing of the insane in the United States and Canada, kindly signify by rising.

Motion unanimously adopted.

THE PRESIDENT.—Major Clarence S. Yoakum, Sanitary Corps N. A., Washington, D. C., will give an abstract of the paper prepared by Robert M. Yerkes, Major Sanitary Corps, N. A., entitled: "Methods of Psychological Examining Used in United States Army."

In presenting this abstract Major Yoakum spoke as follows:

The Division of Psychology of the Surgeon General's office wishes me to express its appreciation for permission to appear before you and to present briefly some of the things that we are attempting to do in connection with the National Army. I regret that the room you are meeting in is not so situated that I can give you the pictures that I brought with me, which would give you a much better idea, I am sure, of what we are doing or trying to do than anything I can say.

Major Yoakum pointed out that the psychologists in connection with the surgeon general's office were called upon to make many mental examinations of all sorts of people in an effort to weed out

those of such a grade of mentality as would be of no use in the army. He said: "The army does not want men who are not allowed to load their guns for fear of injury to their companions; it would be wasting time and money of the government to send men with such low mentality across. In the cantonments where this work was carried on last fall, about one-half of one per cent were recommended for discharge."

DR. PIERSON.—I wish to offer the following resolution:

*Be it Resolved*, By the Seventy-fourth Annual Meeting of the American Medico-Psychological Association this day assembled at Chicago, That we endorse and urge the passage of the two bills of Senator Owen and Representative Dyer, establishing similar ranks for commissioned officers of the Medical Corps and of the Medical Reserve Corps of the United States Army, and on the same ratio as for the Medical Corps of the United States Navy.

*Resolved*, That we hereby give our endorsement and active support to the movement undertaken by the War Department and the Surgeon General's office, and by the boards of health of many commonwealths, to combat venereal disease, and we appeal to our medical profession for their harmonious co-operation of this law.

*Resolved*, Further, That a copy of these resolutions be forwarded to the Surgeon General's office.

I move the adoption of these resolutions.

Motion seconded and carried.

THE PRESIDENT.—The Committee on Awards has a report to make.

*To the American Medico-Psychological Association:*

*Mr. President, Ladies and Gentlemen:* I have been asked by the ladies appointed on the Committee of Awards to do the duty the ladies refused to do.

First, we wish to congratulate Dr. Gahagan, as chairman of the Committee on Diversional Occupation, on the excellence of the exhibit. We also wish to congratulate the New York state hospitals on the magnificent showing they have made and also because they have followed out Dr. Gahagan's suggestion to exhibit a daily program of the work of the individuals in the different hospitals, attaching a card giving the name and address of the institution, the name of the patient, the psychosis, abstract of the history, etc., in connection with the piece of work they exhibited.

We wish to call your attention to the excellent display of the Massachusetts state hospitals, and we wish to particularly commend a far distant hospital—at Napa, Cal.

The first award goes to the Kings Park, N. Y., State Hospital.

A special award to the Napa (California) State Hospital, and a certificate of commendation to the Massachusetts state hospitals.

Respectfully submitted,

*Committee on Awards,*  
By DR. HOBBS.

On motion the report of the Committee on Awards was accepted and adopted.

The following papers were presented in abstract:

"Neuro-Psychiatry in the Army," by Richard H. Hutchings, Major, M. R. C., abstract by Frankwood E. Williams, M. D., New York; "Community Preparations for After-War Problems in Psychiatry," by Frankwood E. Williams, M. D., New York City. Discussed by Drs. Brush and Mitchell.

"A Microscopical Study of Fat in the Cerebral Cortex," by Oscar J. Raeder, M. D., Boston, Mass. Discussed by Dr. Gosline.

THE PRESIDENT.—We will adjourn until 8.30 this evening.

#### EVENING SESSION.

THE PRESIDENT.—The Association will please come to order. The Council has a short report—we will hear it now.

#### REPORT OF THE COUNCIL, JUNE 6, 1918.

The Council has received the application for active membership of H. Mason Smith, M. D., Chattahoochee, Fla. According to the constitution final consideration will be deferred until next year.

The Council recommends:

That Owen Copp, M. D., of Pennsylvania, be elected a councilor for one year, to fill the vacancy caused by the election of Dr. H. W. Mitchell as Secretary-Treasurer of the Association.

That the Treasurer be authorized to pay Professor Paul Shorey an honorarium of \$50.00.

That the incoming President be authorized to appoint a Program Committee and a Committee of Arrangements for the next annual meeting.

Respectfully submitted,

H. C. EYMAN, *Secretary*.

On motion the report of the Council was accepted and adopted.

THE PRESIDENT.—We have with us an assistant surgeon of the navy, whose name appears on our program for a paper; he was unable to get to the city until to-night; he has been traveling several days, but was detained and it is through no fault of his that he is thus delayed. I would ask him to come now and present his paper—Dr. Albert Warren Stearns, Assistant Surgeon, U. S. N. R. F.

Dr. Stearns gave an extempore talk on the subject, "The Detection of the Psychopathic Recruit," in which he discussed the method he had used at the Naval Training Station in detecting mental disease or peculiarity, using the social history as the basis of first judgment.

**THE PRESIDENT.**—*Ladies and Gentlemen:* There are problems which concern us in these days to which we gave little heed in times of peace. To deal with some of them we are devoting this evening to listen to some one outside of the ranks of our Association. I take pleasure in introducing to you Dr. Ray Lyman Wilbur, President of Stanford University, now representing the United States Food Administration, who is lending his services to the nation.

Dr. Wilbur gave an exceedingly interesting and instructive address on the war-time activities of the United States Food Administration. He discussed the question of how far the food shortage has gone and to what extent it has affected the progress of the war; he emphasized the importance of food conservation in America, so that the Food Administration would be able to increase grain and meat shipments to Europe, and also told how definitely the allied nations depend on the American people for their supply of meat and grain in order to win the war. He closed with an earnest appeal to the American people for more of the spirit of self sacrifice in carrying on this war.

**DR. BURR.**—Mr. President, I do not believe in the soft pedal; I do not believe in too much optimism, but I do believe in words such as Dr. Wilbur has given us to-night. Dr. Wilbur, as citizens, we thank you for what you have said and done in the past and for what you have written; we thank you for what you are going to do in the future; we know you will keep right on doing. As an Association we want to thank you for the great privilege of listening to you this evening. I want to move a rising vote of thanks to Dr. Wilbur for this magnificent address.

**DR. BRUSH.**—I am very glad to second that motion, and I think we ought to do something more—we ought to promise President Wilbur that what little sacrifice we have made in the past shall be made ten times as large in the future.

**DR. J. C. MITCHELL.**—I am proud of you American people; but do you know before you took part in this war we Canadians felt very sad about our American friends. We are very closely related and we felt as if we were in this war practically alone; we wondered day after day and night after night if the great American people would not awaken and come to our aid. We felt that this was a great crisis and we wanted your help; we felt that we should have it. To-day the American people have awakened, and we honor and respect you all and we love you far more now. We are very near together and may God help us all that we may carry on until final victory crowns our efforts.

**THE PRESIDENT.**—All who agree to accord our speaker of the evening a vote of thanks and wish to do it in a practical way by promising in future to make greater sacrifice, kindly stand.

Unanimously carried.

**THE PRESIDENT.**—Is there any further business to come before the Association?

Some things are given us often; some, only once; the latter are prized. The sun rises every morning to find most of us asleep; in Lapland the whole population flocks to see the sunrise.

I reluctantly have come to the last few moments of my presidency. My final words would be of gratitude to the entire Association; every member has been most kind; I have been supported on every hand not only by deeds, but by words. I am sure I appreciate them very much, and especially I should mention the help that has been given during the year by the Program Committee; Dr. Mitchell, in spite of difficulties, has produced what you have seen and heard. Also the chairman of the Diversional Occupation Committee; he has come in at the eleventh hour and given us splendid exhibits. Dr. Sanger Brown and the Committee of Arrangements have been most kind, and to all these especially I am grateful.

Will Dr. Kilbourne and Dr. English conduct the incoming President to the chair? He needs no introduction to this Society.

Dr. Southard, now that the flux of time has brought the hour when I may roll the burdens as well as the responsibilities of the presidency from my shoulders on to your abler ones, I pass to you this gavel—the emblem of your office—and congratulate you on your promotion, and the Association on having one so capable to guide its destinies during the seventy-fifth year of its existence.

Dr. Southard, the President-Elect, on assuming the chair expressed in a few brief remarks his appreciation of the honor which had been bestowed upon him.

**DR. BRUSH.**—There has already been passed by this Association some resolutions thanking various and sundry people for different things, complimenting others for various things, and if I remember correctly those resolutions spoke in terms of praise of one of the best and most inspiring addresses from the presidential chair that it has ever been my privilege to listen to. I do not know of an occasion which was so thoroughly utilized and which so inspired the hearers of the address as when we heard from President Anglin at the opening session of this Association. I remember hearing, incidentally, that some one going down in the elevator spoke in terms which were not entirely patriotic, intimating that an address of this kind would cause dissension, etc. I hope the rumor was not true. I did repeat the rumor to our newly elected Secretary and he immediately said, "Show me the man." I took hold of his arm and then felt so sorry for what might happen to the man that I made no further effort to find out who he was.

Dr. Anglin has left before us a standard of patriotism, a standard of loyalty to freedom, to democracy, decency and right, and that address which we shall carry away with us will live with us as long as we live, and I want to move that there be given to the President of this Association our hearty thanks for the manner in which he has conducted the office which we honored ourselves in bestowing upon him.



**THE PRESIDENT-ELECT.**—You have heard the motion; I rule that it shall be passed by a rising vote.

The motion of Dr. Brush unanimously prevailed by a rising vote of the Association.

Dr. Anglin thanked the members for their action.

**THE PRESIDENT-ELECT.**—Is there any further business, with the exception of a few announcements of committees? If not, I will make the following announcements:

Committee on Arrangements: Owen Copp, Chairman.

Committee on Pathological Investigation: George H. Kirby, Chairman; Adolf Meyer, S. T. Orton, A. M. Barrett, H. Douglas Singer, E. E. Southard.

Committee on Occupational Therapy: Major Frankwood E. Williams, Chairman; H. G. Gahagan, W. Rush Dunton, Major Richard Hutchings, Walter E. Fernald.

Committee on Statistics: A. M. Barrett, Chairman; Adolf Meyer, Major E. Stanley Abbott, James V. May, George H. Kirby, Owen Copp, S. T. Orton, Major Frankwood E. Williams.

Committee on Program: George H. Kirby, Chairman; C. MacFie Campbell, H. Douglas Singer, Herman M. Adler, E. N. Brush, H. W. Mitchell.

Committee on Nursing: E. H. Cohoon, Chairman; L. V. Guthrie, James V. Anglin, Daniel H. Fuller, C. I. Lambert.

Committee on War Work: H. W. Mitchell, Chairman; W. L. Russell, G. M. Kline, Major Frankwood E. Williams, W. A. White, Edith R. Spaulding, C. B. Burr.

**DR. OSTRANDER.**—I want to retrieve myself for last evening, so I am going to ask the audience to face the piano and join with me in singing "America."

The members of the Association and their friends all joined in singing our national anthem.

**THE PRESIDENT-ELECT.**—There being no further business, I declare this meeting adjourned to meet in Philadelphia next year.

HENRY C. EYMAN,

*Secretary.*



## PRESIDENTIAL ADDRESS.

By JAMES V. ANGLIN, M. D.,

*Medical Superintendent, The Provincial Hospital, St. John, New Brunswick.*

To this, the seventy-fourth annual meeting of our Association, opened so auspiciously, it is my privilege to welcome you officially.

It was with trepidation that preparations for it were proceeded with in this year of stress, but its carrying on will be justified if our coming together enlarges the common store of useful knowledge; increases our mutual understanding; helps to sweep away obstacles to the advance of the healing art, and quickens us to do our bit in freedom's cause, whose battle-line reaches to our homes, our gardens, and our pockets.

Last year at the closing of the meeting, I took opportunity to thank the members there for selecting me for the presidency of this venerable body, and I now repeat how sincere is my appreciation of this distinction. It is most gratifying to have bestowed on one your best gift, as it expresses what all men covet earnestly—the good-will of one's associates. And yet there wells up in mind the thought, that when in the sunny south I was placed in line for the chair I may now occupy, it was, in part at least, because I was a citizen of no mean country, and the majority of you, holding allegiance to another, sought in some measure to show your younger brother of the north that your heart was with him when he rushed into the fray to fight for the liberty championed by Great Britain, and thrilled that fond mother who had thrown her protecting arms about him from his tenderest years, without other return than his loyalty and love.

Fifty years ago, Canada had her first Dominion Day, when from the position of a group of provinces lying on the banks of a magnificent waterway, she stepped into self-conscious nationhood, embracing a territory which now stretches from sea to sea, and from the river, St. Lawrence, to the end of the earth. Britain's tenure of Canada depends neither on the strength of her battalions nor on the might of her fleets. Within her borders there has not

been stationed since my earliest recollection a single soldier, nor a single cannon over which Britain claimed control. Yet her influence in her great colony has grown more and more powerful. The Canadian people are animated by the same sentiments of loyalty as are found in the isles of their fathers, and British interests are as secure in their keeping as in the very core of the empire.

I need not recount Canada's contribution to the present conflict. Everywhere in this country you have been generous in the extreme in expressing admiration of the spirit of the Dominion.

Germany did not believe that the lion would be able to obtain effective assistance from its whelps in the event of a European war. This opinion must have been derived from the Victorian era, when knowledge of the colonies was vague.

It is only within recent years that British statesmen have shown any real understanding of their dominions beyond the seas. There was a day when one can imagine their welcoming the news that every colony of the Empire had issued a declaration of independence, fashioned on the model of that with which Washington confounded the politicians who surrounded the King.

Canada got on the British map during the Boer war, appealingly and permanently. Over in England they sat up and took notice then, though many who are fighting with us now were not quite sure we were doing the right or chivalrous thing. But most people outside of Germany and Britain did not realize that the Kaiser's cable to Kruger was the formal shying of his helmet into the ring, and the existence of the British Empire was at stake in South Africa. In the darkest period of the Boer war, Canada had sprung to arms, which should have been an augury to Germany of what the colonies would do when their mother was in trouble.

It is a part of our national creed that what the 19th century was to this great neighboring republic, the 20th will be to my country. Canada's soil is destined to support teeming millions. With boundless acres, enriched by wastefulness while the lone Indian scoured the plains, capable of providing the world with the finest of the wheat, with mineral stores of wonders untold, with unrivalled natural forces and virgin forests, with a stern yet invigorating climate, one would indeed be bold who would picture the meridian splendor of the nation which possesses such an heritage.

The most important purpose of such an association as ours is the mutual improvement of its members by advancement in knowledge. No c'ass stands in greater need of getting together frequently than do men of our profession. We are called on to decide complicated problems involving the well-being, yea, the very lives of our fellows. The experience of the greatest is limited. It is easy to stray from the narrow path. There is no corrective equal to discussions with others. In this matter our Association has accomplished much. We have a journal to link us together through the year. It gives an account of our meetings which is a boon for those who cannot attend. Experimenters through this medium can convey information as to their hopes, aims and accomplishments directly, without filtering through foreign publications. That man deceives himself, however, who fancies he can derive the same benefit from a perusal of the JOURNAL as he would from coming to our meetings. He misses the second object to be attained in a society like this—the binding together of its members by means of social intercourse.

Ample time should be allowed for interchange of opinion over the tea cups, or any place as congenial. While there is room for reminiscences not purely scientific, mental stimulus is to be derived from contact one with another, quietly discussing problems about our life-work.

“Our discords, quenched by meeting harmonies,  
Die in the large and charitable air.”

The present time is for all of us one of deepest anxiety, with a great sense of unrest. The angry clouds of war have hung heavily over us for nearly four years, and show no signs of lifting. Many friends are overseas, to mitigate suffering, liable and ready to give their lives, if need be, in behalf of country, liberty, and our ideals of honor, truth and justice. Some dearer to us than tongue can tell are in the fighting ranks, in jeopardy every hour.

With such distraction it was impossible to focus the mind on such an address as you have usually had from the long line of my forerunners, even were such timely, and I capable of keeping to the beaten path. The constitution says your president shall prepare an inaugural. He is not to come here, open his mouth and expect the Lord to fill it. In an effort to obey, I shall occupy further time while you become acclimated to this lake-region with

an endeavor to discover some silver lining to the leaden clouds on which Mars is riding so recklessly. For myself, I was born beside these waters after they had laved Chicago, and so am quite at home. The horrors of war are so constantly present that there may be some consolation in looking for another side.

I remember how in the first days of the war we stood aghast and said it could not endure more than a few weeks; how David Starr Jordan proved conclusively, we thought, that the bankers would never permit a world war to begin; how Samuel Gompers said that labor would prevent the rupture of international peace; and how that brilliant wielder of the pen, Goldwin Smith, had declared that Canadians would never face a bayonet for England's sake. We have lived to see how far astray were such surmises. The greatest conflict in history not only began but has extended over weary years. Laboring men who had pledged their word to protect their alien brothers flew to the colors of the greatest autocrat of all time, and the best of Canadian youth are over there where they have proved themselves of such stuff that no troops have put greater fear into the hearts of the foe. They have shown invaluable initiative, innate to the new world, and your boys will do the same.

So, though the future may not bear one out in taking the optimist's view-point, no harm can follow "reaching a hand through time to catch the far-off interest of tears."

Every evil thing is followed by some good, and every achievement of good only uncovers some further ill for men to combat. Early in the war, in nearly all the belligerent countries, there was a sudden decrease of crime due to the absorption of many law-breakers into the armies, and fewer idle hands for Satan to get busy with. A few months later, however, juvenile crime increased from lack of parental control, the fathers having gone to war, the mothers to work.

Likewise war found work for everybody. Thousands of families who were never far from the starvation line, now earn wages they never dreamed they could command. That is a good thing, but it too has its demoralizing side. Money thus unexpectedly possessed threw men and women off their moral balance, and the saloon has flourished.

It is in these contradictory elements in our progress that ammunition is found for optimists and pessimists. The pessimists claim that the evil counterbalances the good. The optimists take the opposite view and history seems to favor the latter.

Medicine itself is likely to gain little from the experience of war. It has taught the surgeons much about the proper application of Listerian principles; physicians, the efficacy of inoculations against diseases which formerly decimated armies; alienists, the effects of shell-shock. But such advances in knowledge, valuable as they are in themselves, have comparatively little application to ordinary life. The practical humanity of the medical officers, shown in so many ways, is indeed a relief to a contest in which angry nations use every means of destruction to exterminate each other. But the blast of war that blows on our ears makes the still small voice of science inaudible.

Some comfort comes from learning that there is no evidence, in Great Britain at least, that since the outbreak of the war the amount of insanity has increased. There has actually been a decrease in hospital admissions, due mainly to the absence of so many men in the army, who are dealt with by the military if they become insane. Among women, the higher wages earned, and the separation allowances regularly received, have relieved domestic uncertainties. Many who had nothing to do previous to the war have forgotten self by throwing their energies into active work for others. Rich and poor alike are now busy all the time. The result is a vast improvement in the nation's mental stability. People whose lives were empty are interested from morning till night. Work is the surest consolation for the grievous sorrow of war.

Even among the soldiers mental disorders have not been as prevalent as expected. The French conclude that with a few exceptions, in which a pre-existent organic taint was always to be found, the war has not been productive of insanity. It were well, quoth the observer, if the opposite could be said, namely, that insanity has not produced the war. What was chiefly feared was mental disorder among men worn out by the fatigue of the campaign, but such cases have been rare. The circumstances of service in the field react on the mind in so many ways and so

differently from the influences of peace that new forms of mental trouble may result.

The experience of the war is certain to lead to better lunacy laws. There has long been complaint that mental disorders have been regarded on a different basis from physical. Though in no department of medicine is the need greater for the earliest treatment, yet the tendency of existing laws is to cause remedial treatment to be postponed. The trouble arises from the fact that the laws governing these matters were framed by lawyers who are concerned in arranging how people are to be protected. But public health asks how mental sufferers are to be best treated so that they may be cured. The lawyer's view-point though important has been allowed to outweigh all others. The war has made it necessary to deal with the problem in a fresh, untrammelled way. Hitherto, the law has hindered early treatment in many cases by making certification necessary for admission to an institution, by inflicting the stigma of pauperism, and by branding the recent case with insanity with all the disastrous consequences that flow therefrom, unjust though they be. The army has brushed these difficulties aside. Numerous cases of recent mental disturbance among the soldiers have been dealt with in special hospitals without being certified insane in the usual way. Out of nearly 4000 such cases among the British troops less than 200 had to be transferred to an insane institution. The soldiers suffer from the stigma neither of insanity nor of pauperism, and there is no obstacle to the earliest and best treatment. A civilian should have the same advantages when a mental breakdown threatens. There is no essential difference between the case of the soldier who becomes insane in the defence of his country, and that of a woman who suffers from mental symptoms brought on by producing her country's defenders.

The maxim that medical science knows no national boundaries has been rudely shaken by the war. The Fatherland has been preparing for isolation from the medical world without its confines. Just as years ago the Kaiser laid his ban on French words in table menus, so as early as 1914 German scientists embarked on a campaign against all words which had been borrowed from an enemy country. A purely German medical nomenclature was the end in view. The rest of the world need not grieve much if they show



their puerile hate in this way. It will only help to stop the tendency to Pan-Germanism in medicine which has for some years past been gaining headway.

The Germans excel all other nations in their genius for advertising themselves. They have proved true the French proverb that one is given the standing he claims. On a slender basis of achievement they have contrived to impress themselves as the most scientific nation. Never was there greater imposture. They display the same cleverness in foisting on a gullible world their scientific achievements as their shoddy commercial wares. The two are of much the same value, made for show rather than endurance—in short, made in Germany.

While they were preparing men and munitions for their intended onslaught for world dominion, they were spending millions of dollars to win the admiration of both the working classes and the intellectuals of other nations, extolling the superior conditions of the Fatherland, picturing it a paradise, with model homes, short hours and high wages. This was but a cloak for the sinister plans of Prussian autocracy. But how great has been the disillusionment! The facts are its working classes labored longer hours than in any other country and for starvation wages, the women and children toiled like beasts of burden in most strenuous trades, sweat-shops abounded, many suffered from lack of fuel and food, farmers were oppressed with a rigid caste system so arranged that a peasant child could never become other than a peasant. Instead of the villas embowered with flowers, the general mass of workers lived in barrack tenements, gloomy and foul, lacking baths and heat, but with gaudy exteriors as camouflage.

In the earliest months of the war, it was pointed out that there are tendencies in the evolution of medicine as a pure science as it is developed in Germany which are contributing to the increase of charlatanism of which we should be warned. A medical school has two duties—one to medical science, the other to the public. The latter function is the greater, for out of every graduating class 90 per cent are practitioners and less than 10 per cent are scientists. The conditions in Germany are reversed. There, there were 90 physicians dawdling with science to every 10 in practice. Of these 90, fully 75 per cent were wasting their time. In Germany, the scientific side is over done and they have little to show

for it all, while the human side is neglected. Even in their new institutions, splendid as they are in a material sense, it is easy to be seen that the improved conditions were not for the comfort of the patients.

Out of this war some modicum of good may come if it leads to a revision of the exaggerated estimate that has prevailed in English-speaking countries of the achievements of the Germans in science. We had apparently forgotten the race that had given the world Newton, Faraday, Stephenson, Lister, Hunter, Jenner, Fulton, Morse, Bell, Edison and others of equal worth. German scientists wait till a Pasteur has made the great discovery, on which it is easy for her trained men to work. She shirks getting for herself a child through the gates of sacrifice and pain; but steals a babe, and as it grows bigger under her care, boasts herself as more than equal to the mother who bore it. Realizing her mental sterility, drunk with self-adoration, she makes insane war on the nations who still have the power of creative thought.

Alienists have been infatuated with German pseudo-discoveries. Novelty of terminology has been taken for originality of thought and their works on insanity have been accorded undue authority. We ignored the substance in our own and the Motherland, and chased the mirage on the Continent.

Since the German army was successful in 1870, it has been idolized, and the admiration bestowed on it has extended, so that in spite of the fact that the Germans themselves have gone to other countries for their ideas, we have cultivated a superstition of German pre-eminence in everything, but especially in science. There might be some excuse for this if they had made any discoveries comparable with those of the circulation of the blood, of vaccination, of asepsis; all made by men who speak our language; or if German names were identified with important lesions or diseases, as are those of Colles, Pott, Bright, Addison, Hughlings Jackson, Hutchinson, Argyll-Robertson and others.

But it is especially in mental science that the reputation of the Germans is most exalted and is least deserved. For every philosopher of the first rank that Germany has produced, the English can show at least three. And in psychiatry, while we have classical writings in the English tongue and men of our own gifted with clinical insight we need seek no foreign guides, and

can afford to let the abounding nonsense of Teutonic origin perish from neglect of cultivation.

The Germans are shelling Paris from their Gothas and their new gun. Murdering innocents, to create a panic in the heart of France! With what effect? The French army cries the louder, they shall not pass; Paris glows with pride to be sharing the soldiers' dangers, and increases its output of war material; and the American army sees why it is in France, and is filled with righteous hatred. Panic nowhere. Vengeance everywhere. What does the Hun know of psychology? His most stupid, thick-witted performance was his brutal defiance of the United States with its wealth, resources and energy. That revealed a mental condition both grotesque and pitiable.

After the war a center of medical activity will be found on this side the Atlantic, and those who have watched the progress medical science has made in the United States will have no misgivings as to your qualifications for leadership. If we learn to know ourselves, great good will come out of this war.

Since 1914, there has been an awakening of the public conscience regarding health. An impetus has been given by the wonderful results of sanitation in the armies. In this we are interested because bodily disorder often foreruns mental, and many cases we treat are due to an infectious disease usually avoidable. Long ago, Disraeli declared that public health is the foundation on which rests the happiness of the people and the strength of the nation. Statesmen generally are only now recognizing that not only is the well-being of many millions of workers involved, but that the development of a country is checked if due attention is not given to the many problems associated with the maintenance of health.

In my home province this spring, the government has created a health department to give at least as much attention to human beings as it has done to domestic animals or the moose that attracts sportsmen to the wilderness. The more grave the situation in France becomes, the more vigorously should we strive to shield those who can assist in greater production from preventable disease and lessened efficiency. The war has impressed us with the fact that the childhood of the nation is the second great line of

defence and every child must be saved not alone for its own sake or its parents, but for the continuance of the nation.

This war has shown us the value of developing the bodies of our young people. Wherever soldiers have been in the making there has been demonstrated what a change military training brings about in the recruits, converting youths of poor physique into erect, strapping, ruddy athletes. It is hard to realize they are the same human material, but for the first time in the lives of most of them they have learned how to live. When compelled to endure hardships such as they never knew before, or lie in hospital recovering from wounds, the fitness secured by training is a decided factor in their favor. When the cruel war is over and welcome peace has stilled the stirring drum, shall the call for this physical fitness be no longer made? The need of it will not pass away. The demands of peace make it necessary that every youth be made as perfect as possible. And this applies equally to girls. The country which would produce a hardy race must have strong women as well as strong men.

Nationally, we had almost completely ignored the cultivation of the body. We make it compulsory for every child to submit to years at school for the sake of intellectual training. But its physical development has been left largely to chance and nature, and then when we call for soldiers we find a third of our youth unfit. It must be the state's business to attempt in every possible way to develop the physical life of our young people. Even if it meant the taking of a whole year for necessary training it would be a national boon, adding as it would, 5 or 10 years to the life of the individual. The time for trusting to luck and letting things slide has surely passed. Benjamin Franklin said wars are not paid for in war time. The bill comes later. This is a sad truth, but the bill will be settled the sooner if we make the most of the rising race.

The war will hasten some scheme to provide all who need it with medical care. Often among the working classes disease leads to distress and distress to disease, and charity in some form has been obliged to assist in destroying this vicious circle. Free hospitals have arisen but this condition is not ideal, yet the man with meager income must accept this charity. A better plan appears to be that of an insurance under which all wage-earners are compelled while well to accumulate a reserve which will defray part, at least, of

the expense during periods of disability. Some such plan has just been pressed on the British to provide in case of illness or injury adequate care for all persons whose income is less than \$800 a year. Nine-tenths of the general practitioners in the British Isles have entered into the scheme.

On this Continent, little attention has been given to a measure of this kind, but it seems probable that whether medical men like it or not a similar one will become law on this side of the Atlantic.

The war has brought about a curtailment in the abuse of alcoholic drinks. For some years past there has been a revolution going on in regard to intoxicants. The world-wide attack on liquor at the outbreak of the war was simply the crystallization of an antagonistic sentiment which had been slowly forming based on scientific evidence of the physiological and social effects of alcohol drinking.

There is no reason to suppose that the great temperance wave is a passing thing which will ebb when the excitement of the war is over. Unless all signs fail, it represents a permanent gain whose far-reaching benefits members of this Association will be the first to appreciate. It is not the moral reformers who have brought prohibition to pass. There is now a solid body of educated sentiment behind the law. Business corporations are roused against the liquor traffic as they certainly were not 25 years ago, because they now recognize that whiskey and efficiency make a poor team. The world has traveled a long way since that first teetotaler applied for life insurance and was charged an extra premium because total abstinence was so dangerous to health.

Social standards even in England, which still retains a bad pre-eminence in drunkenness, have marvelously changed since the days of Charles Dickens, who was quite unconscious that intemperance was anything more than an amiable weakness of generous and convivial hearts.

We are abolishing the bar. We still have the bottle. The quack-medicine vendor is busier than ever. Money is plenty and he wants some of it. He uses mental suggestion and interests us. He is a specialist in distortion who probes into the ordinary sensations of healthy people and perverts them into symptoms. Every bill-board, newspaper, fence-rail, barn and rock thrusts out a suggestion of sickness as never before. The only

vulnerable point to attack the vicious traffic is the advertising. If governments forbid that as they should, the next generation will be healthier and richer. If we are going to let imagination play let us exercise it on suggestions and symptoms of health.

The world is moving rapidly in these days and to women is being granted their rightful place. They are being given the ballot, not as a reward for what they had done in the war, but because they possessed the patriotism and the intelligence which entitle them to share in the conduct of public affairs.

We have been struck by the readiness with which our boys have responded to the country's call, and have admired their cheerfulness, but more impressive has been the heroism of the mothers, the wives, the sweethearts and the sisters, who have sent forth the best we breed without a murmur. Theirs is the harder task to go quietly on with the daily routine while the heart is in France with the boys they love. While many talented ones have been prominent in public service, behind them lies a great army of women who are not known outside of their own small circle, and who are yet the nation's richest possession, its most sacred trust, who make life attractive, and freedom possible and worth while. We would never have had such valiant armies in France if it had not been for the brave women at home. The advent of women into political life means purer government and the coming of long overdue reforms in the laws of the land.

Even our religion will be a better brand because of the war. Creeds count for little over there and will never again divide men as they have done. Less and less emphasis is put on the sweet bye and bye, and men's thoughts are turning to the service of their fellows here and now. They are recognizing the practical unity of religion and the square deal all round.

And so it will come to pass,

"That mind and soul, according well  
May make one music as before,  
But vaster."

The war is teaching us the value of thrift, that exceedingly useful virtue which most men practise only when they must. But unpopular as it has been, stern national necessity is now helping to restore it to its rightful place. On this continent we have not as yet gone far in this direction. But in the Motherland there is another story. For over two years not a single new pleasure

auto has been manufactured. Big social functions are not merely bad form—they have ceased altogether.

The traffic in luxuries in certain cases has been entirely wiped out. Everybody is wearing old clothes and saving the wool for the boys in the trenches, and saving the food that the army may be properly fed. England is practising economy such as she never did before, and the strange thing is that apparently business is better than it was in the days of more luxurious living. One reason for this condition is undoubtedly the fact that everybody is working. The scale of living for the rich has been lowered, but the scale of living for the poor has been raised. This is probably a help to both. The pinch really comes, however, on the middle classes whose salaries have not increased, but whose expenses have gone up by leaps and bounds. And yet there is no grumbling. The men who grumbled at everything in pre-war times are now silent when they have really something to grumble about. England in prosperity may sometimes be hard to put up with, but England in adversity is magnificent.

The war has done much for us if it has done nothing more than to reveal men to us. Before the war, we judged them by their petty virtues or petty faults, and we thought we judged correctly; but now we see that under it all lay a capacity and a willingness for self-denial and cheerful self-sacrifice that we had never suspected. The real nature of men has come to the surface, and we stand amazed at the goodness and grandeur of it. On this side the Atlantic, we have not yet seriously tackled the luxury question, but we shall have to deal with it in radical fashion, before our war debts are paid. Luxuries, whether they be costly or the smaller ones in which poorer men indulge, are not a necessity to national development or to individual happiness, and their abolition does not either ruin trade or make men discontented and unhappy. If the war teaches us this it will mean much for our future national and individual well-being.

Hospital superintendents, who are responsible for maintaining hundreds of lives and the operation of many acres, may be vital factors in both saving and producing, and thus play the game. It may be the only war service some of us can render.

With France all the time within a few days of starving; with Great Britain relying on us for 65 per cent of her essential foods; with the wheat of Argentina and Australia too distant to be avail-

able, Northern America must step into the breach to avert famine for a warring world and the fate that has overwhelmed the greatest empires of the past. A time of food shortage is at the door. It is hard to take it to heart while money is plenty. But money will not take the place of bread. By eating no more than we need, and by stopping waste, a good deal can be done to relieve the situation. At any rate, a good habit will have been formed.

But the common sense way of undertaking to prevent famine is to increase the food supply. This cannot be done in every land. Some nations are cultivating every foot that has not a building on it. But on this Continent the case is different. Here there are yet countless acres waiting for the breaking plow. In Great Britain they are tilling every available plot, and it is of just as vital importance to us that we increase production here as there. We are equally concerned in the outcome of the war.

Recently governments passed a law enacting that every able-bodied adult must be engaged in some useful occupation. If enforced without fear or favor it would set to work the tramp and the pampered son of the foolish rich man alike. Everyone would become a producer of wealth. It would be good for the country and still better for the idler himself. Idleness, whether of the poor or rich, is a crime against the state and is also the fruitful parent of vice and degeneracy. Ideals are changing; the gentleman is now a respectable citizen who toils in his country's service.

Distant though we be from the din and smoke of the battlefields, there is opportunity for us to prove ourselves heroes in the strife. These stars must not be left to do it all.\* Each should take to heart that,

"It isn't the task of the few—  
The pick of the brave and the strong;  
It's he and it's I and it's you  
Must drive the good vessel along.  
Will you save? Will you work? Will you fight?  
Are you ready to take off your coat?  
Are you serving the State?  
Are you pulling your weight—  
Are you pulling your weight in the boat?"

\* Referring to the "service flag" behind the speaker's desk with more than 90 stars, representing members of the Association in the army medical service.



There are not a few who, over three years ago, were almost wishing that they had never lived to see such a dire day as was then dawning, but who have come to see through the years that the dark day of tragedy was also a day glorious with opportunity and destiny. It is even now said that had the war been won two years ago, it would have been the worst thing for our nation, as its lessons had not been learned.

A new and better day is coming for this war-wrecked world. The sea before us is uncharted, and there may be much that differs radically from the past, but we can only do as Columbus did—sail on.

A new spirit is moving in the masses of society. Men's ways of thinking are changing more rapidly than at any other time in history. Before the war it was said that to spend 25 millions yearly on social reforms in Great Britain would mean national bankruptcy. Now it is found that more than that can be spent in a day to ensure the national safety. It will be found after the war that great expenditures to improve social conditions will come as a matter of course.

The soldiers will return with enlarged views of democracy and social justice. The rich and the poor, the learned and the ignorant, have together looked death in the face. The sense of brotherhood and comradeship has been immensely strengthened. Those who were less favored under the old social system will be inclined to demand justice and equality. Those who were more favored will be inclined to concede the demand. Artificial distinctions of rank and even distinctions founded on superior capacity and learning, fade away before the proof of the common virtues of manhood. The equality that is sought is the equality of brotherhood and of rights.

Just as in war time, so it must be in time of peace—the good of the country, the well-being of the many, must prevail against the privileges and over the rights of few. This is good politics. It is true patriotism. The world is going to be a better place for the great masses of men. If we can but keep up the habit that we are to-day learning of being world citizens, interested in great enterprises outside of ourselves, then we would be helping to build the democracy of the future, which must more and more become a society in which duties are greater than rights, and to serve a finer thing than to get.

If in these introductory remarks I have not been able to detach myself from the world's most serious business at the present time, perhaps on reflection they may not have gone very far afield from the subject which binds us together in an association. If there is to be a change in the conditions under which we live this must have its effect on the minds of men; whether for good or ill, I will not stop to speculate. We are intensely concerned with environment. This war itself is entangled with it.

England's greatness, her devotion to honor, truth, and fidelity, is due to the environment in which her children are trained and grow to manhood.

The ivy-grown wall, the vine-clad hills and the rose-covered bowers constitute the birth-place of English character.

Gerard tells us the cause of the war is the uncongenial environment in which the German youth is cradled and reared. The leaden skies for which Prussia is noted, its bleak Baltic winds, the continuous cold, dreary rains, the low-lying land and the absence of flowers have tended to harden the spirit and rob it of its virtue, produce a sullen and morose character, curdling the milk of human kindness.

It is a greater pleasure than usual for Canadians to meet with their American cousins in this year when our two countries are joined in the grim but glorious comradeship of war in defence of the heritage and aspirations that belong to us both. Our fathers came from common soil, their veins flow common blood. For over a century we have lived as good neighbors in the friendly rivalries of peace. Through proximity we have adopted more and more your ways without becoming a whit less true to the British flag.

After this war we will be still better friends. We will have been in a fight together and on the same side. We will carry flowers across the seas to lay on mounds in the same clime. The boys who come back will have the same stories to tell of struggles and triumphs. Let us hope that the present is the dark hour that precedes the dawn, and that ere long the sky may be fired with the red glow of the rushing morn; that soon the shot that brings victory—the last one—may be heard, and if it come from an American gun, no Canadian will begrudge you the lucky honor.

The war has achieved much in cementing the two great English-speaking nations of the world as nothing else could possibly have done.

Great Britain and the United States have never before fought shoulder to shoulder, but they are doing it now, and the fact is one ominous to their enemies. A common peril has united them, and a common aim will perpetuate the union. To no group of people will success in the war mean more than to the Anglo-Saxons, and the fact that this great family will in future dwell together in undisguised confidence and good-will is worth in itself all that the war has cost.

The Allies are depending on this land for food and men, for ships and guns, for ammunition and aeroplanes, and this is leading Britain to recast its views of the United States, and is leading the latter to regard Britain in a more favorable light than ever before. The old suspicions and the ancient grudges are being melted away. Years of misunderstanding were trodden underfoot when American boys marched through the streets of an amazed and admiring London.

It had long been a reproach that on this Continent men cared for nothing but the almighty dollar and made gold their hope, but when the call came to sacrifice for the good of the Allies no nation ever responded more gladly or liberally. Britain asked for meat, all you could spare, and you answered with meatless days, with the result that the United States has been able to supply millions of pounds more of bacon and beef than were expected. To-day the British workman has his normal supply of meat, thanks to America's response.

Germany never played more clearly into the hands of her foes than when she scornfully defied the world's greatest republic, in the mistaken conviction that while the United States was of great potential strength she would not dare to challenge the mightiest military machine that ever cursed the world. But Germany's blunder will prove the world's salvation if it succeeds in binding together in friendship, the two great peace-loving, freedom-cherishing, English-speaking democracies, Great Britain and America.

In 1493, a tiny barque, frail and scarred by many a storm, the first craft from America, returned to the shores of Europe. She bore what was then termed the richest freight that ever lay upon the bosom of the deep—the tidings of a new world beyond that vast waste of water which rolled in untamed majesty to the west.

That was a year of good news for the people of Europe. The thirst for gold was as keen in the 15th century as it is to-day and the discovery of Columbus disclosed to monarchs and adventurers alike visions of wealth.

Little could they reckon that in this year infinitely more precious freight would be borne across the same pathway, when ship after ship, leviathans of the deep, would bring from that new world to somewhere in Europe, offspring of the sturdy pioneers from the old land, who in braving the savage forces of nature had found liberty, legions of brave and noble men, in martial array, with the star-spangled banner at the mast-head, to reveal to the war-bound nations visions of something with which those of the wealth of the boundless West or the gorgeous East could not compare—visions of freedom for all mankind.

Thank God! "Our fathers' God, to whom they came in every storm and stress," America did not turn a deaf ear to the laureate's apostrophe:

"Gigantic daughter of the West,  
We drink to thee across the flood;  
We know thee most, we love thee best,  
For art not thou of British blood?  
Should War's mad blast again be blown,  
Permit not thou the Tyrant Powers  
To fight thy mother here alone,  
But let thy broadsides roar with ours."

## THE PSYCHOLOGIC TREATMENT OF RETARDED DEPRESSIONS.

By L. PIERCE CLARK, M.D., NEW YORK CITY.

It is unfortunate that practically during the last decade only has any consistent or methodical effort been made to treat the benign psychoses on the basis of their psychogenesis. Even now I fear these mental disorders are in the vast majority of instances treated by physiotherapy of baths, exercise and occupations, leaving the large domain of mental therapy *per se* to the chance attention of friends or sympathetic attendants and nurses. It is not that a somatic approach to these psychoses is to be deprecated, but no one will deny that the individual as a whole is not properly considered until a mental therapy in a more specific manner is also instituted. One may contend that in the last analysis the benign psychoses are organic; nevertheless another may retort that the mental symptoms themselves are as truly organic and treatment of them is as surely a somato-therapeutic approach to the problem as considering the infections and disturbances of metabolism that may be found therein. However this may be, as psychiatrists we should hold that nothing less than the most inclusive therapy for handling the benign psychoses should be our united aim in this special field. In view of the fact that our treatment of the retarded depressions, especially in private practice, has had such a *laissez-faire* attitude attached to it, for several years I have given special attention to some cases of this type, first, to see if we may not make the recovery from individual attacks sounder, and secondly, to discover a possible manner of preventing recurrences of such episodes in these cyclothymic individuals. Inasmuch as I have already reported fully upon a series of cases of retarded depressions treated by mental analysis, a brief summary digest of the results in some of these cases at this time may be given. A complete detailed report of the same will be published elsewhere. In addition to the usual approved physiotherapy of baths, diet, occupation, recreation and the like, I employed a modified psychoanalytic reconstruction therapy.

CASE I. The first case handled by this method was that of a married woman who had passed the climacteric and who had two periodic depressive attacks yearly since her twenty-fourth year. The attacks were those of simple retarded depressions. Intensive treatment for several months was undertaken. In spite of the incompleteness of the analysis and the age of the patient, she has had no subsequent attacks for a period of over eight years. Furthermore she has been unusually free from any of the interval symptoms.

CASE II was that of a middle-aged widow who also had passed the climacteric. She had had several recurrent periodic retarded depressions. She had short periods of depression every five or six months for 15 years. Since a brief and incomplete course of treatment she has had no more depressions—a period of over five years' freedom from any attacks.

CASE III was that of an unmarried man in the middle thirties who had had several attacks of retarded depressions in a space of 13 years. He has been entirely well for over five years. In the usual order of his psychosis a subsequent attack might have been expected within two years.

CASE IV was that of a married woman who had passed the climacteric. She had her first attack of retarded depression at 22 years of age at the death of her first child. The attack lasted a year. Since that time she had had recurrent attacks nearly every year lasting several months each time. The analytic treatment was given for the greater part of a year. For the past three years she has had but slight vestigial symptoms but has had no actual retarded depressions.

CASE V, a married woman now in the late twenties, had her first attack at 17 years. There were but slight symptoms of depression without retardation for a few months at that time. It followed an unfortunate love affair. Her first pronounced manic attack followed her first childbirth. She has had several severe manic-depressive attacks with scarcely a stable or free interval between complete attacks. She often had to be restrained and twice attempted suicide. Following a short but intense manic attack she was removed from a sanatorium and given a six months' course of analytic treatment during the depressive phase of her disorder. The results in this case have been extremely satisfactory; she has remained entirely free from attacks or even the slight though unmistakable vestigial symptoms for two years. She has passed through her second childbirth naturally. After a most intensive scrutiny of her mental life, all agree that she has not been so normal as she is at present for 10 years or since she began her pronounced manic-depressive career.

CASE VI is that of an unmarried woman of late middle life who had had a circular type of disorder for 10 or 15 years. For a few years before she was given a six months' course of treatment, the regular alternation of excitement and depression had been sharp and of the classic type. The treatment was given at the end of a depression and through an entire excitement period. The patient was mildly hypomanic throughout the treatment. It is interesting to note in this case that a distinct paranoid trend was soon analyzed away and has not returned. The patient remains mildly hypomanic with clear insight and with excellent power and capacity

for work. She has now successfully passed two periods of depressions and is at this report practically without vestigial symptoms. There has been a long series of other and similar cases treated, but too short a period has passed to make one certain of the real or superadded advantages of analysis over older and more common methods in vogue for the care of such cases. For instance, a man of 43 years, in his second marriage finds he is "really married" for the first time, in that his present wife fulfills the longed-for attentions of his mother who died several years ago. He came with a history of many recurrent retarded depressions followed by mild elations since his first "marriage of convenience." It was really the death of his mother and his present wife's serious illness at the same time that brought on his last retarded depression. It was obvious from his symptoms and dreams at the beginning of the analytic treatment that the retarded depression was already lifting. This analysis made the rate of recovery about twice as rapid as that experienced in previous attacks. After several treatments he became quite free from his depression and was mildly elated, as is usual following his depressions. Unfortunately, as is common, he then saw no reason for further treatment. As soon as the depression disappeared, it was interesting to note the great improvement which the marked cardiorenal disease underwent. He had this latter physical disorder for years. Another case was that of a young unmarried man of 29, who had a depressive make-up. There were several in the family of the same type. An uncle of this young man in his seventh retarded depression was relieved in a few weeks following a short course of analysis, and he insisted that his nephew should follow the same treatment. It was obvious from clinical symptoms that the young man had nearly reached the end of his depression; however, after a preliminary analysis he was released almost immediately of his remaining symptoms. He promised faithfully to return for complete analysis but, again, as is usual under such circumstances, he never did.

From my experience in treating a score of cases by intensive mental analysis I would say that the ideal type of case for this method of therapy is an individual who is young and who has suffered from as few attacks as possible. Inasmuch as the analysis is often very painful to such retarded depressants, the strictly analytic treatment must be for short periods, often for half an hour only. The analysis of the conscious and foreconscious life had best be considered first, then should follow a complete dream analysis. If there has been an actual manic excitement in the cyclothymic, the spontaneous productions obtained during the elation furnish an almost ideal material for consideration, as these may be considered, at least for practical purposes, as direct emanations from the unconscious. The depressive ideas themselves may be analyzed, but these are often so confused and distorted that

dream analysis, as in the strict neuroses, is the best method to arrive at the real conflicts. By keeping sharp watch of the dream content one can usually judge whether or not the analysis is being pushed too rapidly; that is, if it is too fast, stress and suicidal symbols begin to present themselves as resistance to the treatment. Only one of my patients feebly attempted a suicidal act.

As might be expected, the transference is extreme in analyzing these depressants, but this need concern one but little, as the normal, or the hypomanic, state will quickly remove it. The retarded depressant rarely or never leans upon the physician as the neurotic may after incomplete analysis. It is perhaps unfortunate that severe depressants are not analyzable and that not many even in their mild hypomanic states can be treated in this manner. The beginning or the ending of a severe depressive period are the most accessible states for treatment. The latter part of the depressive episode is possibly preferable, as one then has the whole historical present to work upon. Sooner or later, however, the whole life of a case must be gone into minutely if the treatment is to be fully successful. In no case have I failed to find Hoch's general principles of the mechanisms for retarded depressions which he has laid down in his "Study of the Benign Psychoses." \*

In conclusion I would reiterate that an intensive analysis should be made in every carefully selected case of retarded depressions encountered in intra- and extra-mural practice. I feel convinced that by so doing many such individuals will make a sounder recovery from the specific attack and recurrences in the after-life will often be avoided. Physicians in sanatoriums and in private practice are particularly urged to try this method in the milder types of the disorder, which often masquerades under such designations as benign depressions, neurasthenias, and the like. Finally, I hope state hospital physicians will undertake this analytic plan more extensively in their severer cases, especially so soon as convalescence is well established. I am sure the extra-mural life of these depressants after discharge will be the better for such treatment.

\* Hoch, Johns Hopkins Hospital Bulletin, May, 1915. For those who may be unacquainted with his views, the original paper may be consulted, or a summary digest of it may be found in my second paper upon retarded depressions, "Some Therapeutic Considerations of Periodic Mental Depressions," Med. Record, Feb. 9, 1918.



## THE CONTENT OF THE SCHIZOPHRENIC CHARACTERISTICS OCCURRING IN AFFECTIVE DISORDERS.

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The more pronounced schizophrenic processes present usually the appearance of discrepancies in thought and reaction, defects in interest and emptiness or silliness of affective response; but frequently the *content* of the various stages in this development, the substance expressed in the oddities of behavior, is obscured by the absence of affect, and by the seclusiveness and inaccessibility. The observer must then be content mainly with a surface description of the mannerisms, grimacing, peculiarities of speech and explosiveness of tantrum, which leave him with as unsatisfied a feeling as though he were looking at a mutilated picture in which he pieces together the fragments with the help of his imagination, or permits them to lie unassembled, open to hardly more than a description of their shape and texture. It is a matter of common experience that numerous schizophrenic symptoms occur either singly or in constellations in affective psychoses, where the affective response is primarily congruous but is associated with some degree of projection and distortion. This group of "atypical" affective disorders appears particularly favorable for the study of the content and origins of the schizophrenic features included in it: the patients are frequently accessible, the disorganization is neither so complete nor so bewildering as in many cases of the outspoken dementia præcox. The present paper deals essentially with the schizophrenic *content*, leaving the prognostic evaluation and the dynamic interpretation of the symptoms for further analysis and communication. In this series of 40 cases, these symptoms fall according to their form into five classes: (1) Distortions and misinterpretations of actual occurrences (delusions of reference and persecution); (2) influence and passivity feelings as expressed in automatism, mind reading, electrical influence and similar phenomena; (3) hallucinations; (4) gross

distortions of body sense and body appreciation; (5) incongruous behavior, occurring either episodically as "antics," or more persistently but not in keeping with or apparently motivated by the prevailing affect.

Of the schizophrenic characteristics seen in these "atypical" affective disorders, the distortion of actual events is apparently the first and readiest step in the process of projection. Ideas of reference occur in over half the cases studied. These are usually met as beliefs of the patient that the behavior of others is fraught with meanings especially applicable to himself: that others are discussing his discomforts, making remarks or doing things to deride him. The delusions appear related especially to a sensitiveness which makes the patient irritable to the criticisms of others, which he cannot assimilate as rational standards such as would serve as guides or be of corrective value to him; but rather as criticisms which make him hide his difficulties lest they excite unfavorable comment. This fear of criticism, mingled with the actual conviction of its existence, is but a step from the line which every individual crosses occasionally and is generally designated as "self-consciousness" or simply as "touchiness." But when the fear becomes so dominating that the individual no longer suspects only those who might have knowledge concerning him, but feels that he is the object of talk among strangers or casual acquaintances, mere touchiness has indeed reached a degree obviously pathological. Ideas of reference occur in affective states in proportion to the degree of defense which the person feels he must place between others and the situation which he himself finds unacceptable: they are determined not only by the constitutional sensitivity furnished by the individual but often are plainly the real upshot of crucial situations which involve some fear of detection. For example, the man who has lost his position may unreasonably feel that others suspect his failure and are looking at him with contempt or pity; and the elated lover may feel that others share his exuberance or read his triumph. Many of the delusions of reference in affective disorders occur also as substantiations of the affect—especially in the depressions, where there is a bolstering up of the self-condemnation by the conviction that others are similarly condemnatory. It becomes necessary then in considering the significance of the interpretations of

reference to determine their relation to the onset of depression: whether they are mainly secondary; of the character of substantiation, or whether they are an early symptom—the first step in projection and then usually associated with peevishness rather than sadness. A further step consists in feelings of persecution which, in the affective psychoses, are usually elaborations of the reference ideas, with which they are commonly associated, and with which they present fundamentally the same problem. Their onset appears frequently to be determined by definite situations of disappointment: the patient finds himself inadequate in that his ambitions and expectations are unrealized, yet he is unable to accept his insufficiency without placing blame, which concentrated on himself (without analysis) feeds his self-accusations of unworthiness, or, when attributed to his associates, becomes the nucleus of a feeling of injustice, slights, or aggressive persecution. Illustrative of this mechanism is the following case:

F. S. B., a pharmacist of 41, who came to the clinic in 1915 with the complaint of depression. He had been a seclusive, rather dull child, who graduated from the eighth grade at 18 and then took a correspondence course and became a pharmacist, and for the past 10 years worked in an institution. He was over-scrupulous, tried to be perfect in his work, although he was actually mediocre, and he worried. At 40, after losing his savings in a bad investment, he became depressed and upset, for this meant that he could not marry as he had planned. After about six months of depression, he began to be suspicious, felt that the bank officials had purposely ruined him; that others envied him his job and were trying to lead him into drink so that he would lose his position. He then became afraid that a woman with whom he had illicit relations would inform his fiancée. He went to his mother's home where for two weeks he lay without speaking. On admission to the clinic, a few days after this, he was moderately depressed, kept apologizing for trivial things which he seemed to feel he might have done wrongly, he acted as though he expected to be ordered around like a child. For 10 days he remained for the most part in bed—mute, rigid and cataleptic; then he gradually improved and in two months had returned to his former level. Here we have a man who early showed a tendency to sensitiveness, set standards much beyond his mediocre assets and consequently burdened himself with a large number of disappointments. At 40, his marriage is blocked by his loss of money. But the disappointment is not accepted by the patient; it was at first met rather naturally with depression, but then by evasion and projection of the disappointment responsibility.

Delusions of influence and passivity feelings are seen in states of automatism, convictions of active and passive mind reading,

sensations of electrical currents, or of hypnotic influence. Their content varies as widely as do the life experiences of the individual; on the one hand related frequently to the type of mystical craving and credulity which moves people to consult spiritualists, and ouija boards, or seek outlets in theosophy and occultism. Often with their specific content determined in this way, they become linked in the depressive states with the persecutory ideas: the patient projects the aggressiveness onto his enemies, feels himself as the passive victim of their plans and supernatural devices. The sensations of electrical influence, however, are almost uniformly, poorly appreciated, erotic sensations and are about equally frequent in elations and depressions. The ambivalence of power expressed in the patient's belief that he can exert as well as feel influence, send as well as receive messages, etc., occurs oftener in the excitements, is seldom fixed or rigid in content, and appears rather in keeping with the push and exuberance of the elation.

Hallucinations appear in 20 cases of the series, always associated with other evidences of projection. The character of their content is found to be fairly, consistently different in the elations and the depressions. In the latter they are met always with delusions of reference, and frequently also with persecutory notions, and are consistently accusatory or condemnatory in substance, thus representing one part in the projections of the self-accusations of the individual. In the elations, however, hallucinations appear frequently detached and topical (sometimes with symbolistic value) probably in relation, on the one hand to the general distractability, or on the other hand to a fairly extensive fabric of fantasy, especially in the dreamy elations where there is little over-activity and the productiveness lends itself to imaginative creations rather than active excitement.

The delusions of body distortion—appearing as complaints that the eyes are queer, that the hands are claws, or the stomach and intestines closed up, are relatively infrequent and occur almost exclusively (there was one exception) in the depressions. Most of them seem to be "complex determined," in that they relate to subjects of individual sensitiveness. Here the belief that the eyes are queer based on a masturbation-fear-of-insanity complex was strikingly prominent. The feelings of brain change, some times similarly determined, are sometimes also apparently related

to the general depressive retardation and feeling that the thoughts come slowly. Another small group of cases might be classed with the depressive hypochondriasis—in which the physical complaints are crystallized into convictions of definite, and frequently vividly described lesions, which bear the brunt of the depression and replace a sense of being out of gear and harmony with the surroundings.

Incongruities of behavior—startling antics which the patient performs quite in contrast to his prevailing mood—appear on the surface as unmotivated inexplicable stunts; such things as a sudden sliding onto the floor, crowing like a rooster, clownish somersaulting, etc., appear appallingly queer on the surface, although in many instances the connections and associations can be determined by an examination of the individual's ruminations and subjects of pre-occupation. In the elations the antics play a rôle similar to the hallucinatory experiences, a symbolistic attitudinizing of some dramatic value, the patient's inconstant participation in his own fantasies. The other type of behavior antics occurs usually in states of tension during depressions, where the tension is exteriorized in oddities which represent the individual's conflicts: not infrequently with pre-existent fear of insanity and a certain willingness to live up to its realization. In the accompanying case the patient was seldom in good enough contact to discuss or state freely the content of her psychotic behavior, which was, however, sufficiently suggestive to be worthy of examination.

Lillian G. was 45 years old at the time of admission in May, 1915; a widow who conducted a boarding house. There was little known of the patient's earlier life. She was said to have been a healthy, not especially moody, responsive, normal woman. She married at 30, and had one child. Her husband died after five years; and she then began conducting a boarding house. A few months before admission she suffered pain in the back, at first thought to be due to floating kidney, but in January, 1915, recognized as a tuberculosis of the spine. Immediately after learning this, she became greatly depressed, at night would feel she was dying, slept little and became very tense. In April, she cried a great deal and had periods of agitation in which she rocked back and forth in bed. On admission she was tearful, frankly depressed, but pre-occupied and somewhat irritable if questioned. Her orientation and memory were unimpaired. Most of the time she was dreamy and inaccessible, but this behavior was punctuated by short periods when she would neigh like a horse, then pant and blow her lips. She accused another patient of reading her letters, but otherwise made few spontaneous statements. She remained with us only five weeks,

during which she continued markedly depressed, had ideas of reference—thought visitors read her mail, that “everything was being published in the paper”; that the victrola was saying things about her. She had auditory and visual hallucinations, always of a depressive persecutory nature; that she heard people telling her daughter she had sinned; she saw her daughter outside crying for her; heard devils laugh, and saw her daughter’s face. From time to time she neighed like a horse. Once she looked at her hands and said she thought they might have become cat claws. At another time she threw her wedding ring into the toilet. So far the picture appears fragmentary, a bizarre and incongruous assortment. But the underlying moving factors, the real content of the behavior, was made more explicable, when on a few occasions the patient spoke of being punished in hell for her sins: her cousin, a prostitute, had lived with her since her husband’s death. She herself had had illicit relations only on one occasion, had become pregnant and induced an abortion. She felt that this, if known, would damn her daughter, that people might doubt her marriage and think her daughter a bastard. She threw away her wedding ring “because it did not have her initials on it and might have belonged to anyone.” She felt that in the next world she must be further punished, that she might even be turned into a cat, but she never explained the horse neighing. Evidently the tuberculosis focused her fears of death, and accumulated her self-accusations and contritions which then became projected.

To summarize in general review the content of the schizophrenic characteristics in cases showing dominantly an affective reaction, I would emphasize: (1) The prominence in depressions of the symptom constellation of ideas of reference with delusions of persecution and condemnatory hallucinations; (2) an analogous projection of the affect in the varied and dramatic hallucinations; the symbolistic attitudinizing, and the somewhat egotistical and constantly changing ideas of reference of the elation; (3) the determination of the content of the distortions of body sense and of the odd, fixed antic behavior by the underlying conflicts and personal difficulties.

A CRITICAL REVIEW OF THE PATHOGENESIS OF  
DEMENTIA PRÆCOX, WITH A DISCUSSION  
OF THE RELATION OF PSYCHO-  
ANALYTIC PRINCIPLES.

By MICHAEL OSNATO, M. D.,  
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The absence of any material advance in the elucidation of the problem of the pathogenesis of dementia præcox is discouraging. This statement does not hold good if one is satisfied with the psychological explanations advanced. Nevertheless, the psychologist, who is also a student of pathology, anatomy and physiology, will find it hard to be perfectly content with the various psychobiological explanations given for the precipitation and continuation of the psychosis which we know as dementia præcox. The importance of clearing up the problem of the cause of this disease cannot be too emphatically stressed. Centering about it are numerous related problems concerning difficult and abnormal mental states which will be solved by a satisfactory clearing up of the dementia præcox situation. I refer particularly to hysteria, various compulsion—and psycho-neuroses, some types of alcoholic psychoses and other toxic mental states in which manic-depressive insanity may be included. The difficulty of beginning an investigation into the pathogenesis of dementia præcox is readily realized when we stop to think that within this classification are usually placed a number of widely different mental and related physical reactions, which necessitate subdividing the great group into eight or nine subgroups, all more or less indefinite in their clinical manifestations. Few of these subgroups have definite pathological or clinical criteria which can serve as a basis for diagnosis. No specific serological, bacteriological or other laboratory tests can aid us in placing any given mental reaction in the group of dementia præcox or in any of its subgroups. Post-mortem examinations also fail to establish absolute diagnostic criteria, so that we are necessarily driven to the application of certain clinical standards for the diagnosis of dementia præcox. In order to begin from a definite premise, it is necessary for the purposes of this discussion to state what it is that we understand as dementia

præcox. The definition offered by Meyer<sup>2</sup> is advanced. This includes "those types of defect and deterioration which show the existence or the development of fundamental discrepancies between thought and reaction, defects of interest and affectivity with oddities; dreamy, fantastic or hysteroid or psychasthenoid reactions, with a feeling of being forced, of peculiar unnatural interference with thought, frequently with paranoid, catatonic or scattered tantrums or episodes."

The main points, therefore, which require stressing in order to obtain a conception of what is meant by dementia præcox are three: First, the discrepancy which is so characteristic between the thought processes and the emotional and volitional reactions of the individual; second, the defects in the fields of interest and affect, and third, the feeling of being influenced in the performance of acts or thought processes. Any one of these symptoms or any combination of them are absolutely essential to the diagnosis of dementia præcox. The character of the mental or physical reactions will determine whether the case should be called one of the paranoid, catatonic, schizophrenic, hebephrenic or paraphrenic type. Some deterioration, particularly of the will, affect and interest, must be present in every case aside from the delusional trends and hallucinatory episodes. It can be readily seen that these considerations are a matter of personal observation, deduction and evaluation on the part of the individual psychiatrist. Therefore, they cannot serve as absolute criteria. Admitting this fact, nevertheless, it is not helpful in the elucidation of this problem to refuse to recognize dementia præcox as a clinical and pathological entity entirely. This the psychoanalysts of various schools have seemed to do. I have searched in vain through the writings of Freud, Jung, Brill, White, Wells and others for any attempt at clinical classification of their observations in the so-called functional psychoses. The terms dementia præcox, hysteria, psychoneurosis, psychosis, neurosis, etc., are used with no attempt at definite conceptions for any of them. It is not my intention to discredit the psychological investigation of these problems, but surely the teachings of medicine in other fields where progress has been made by empirical grouping of symptom complexes should not be disregarded in psychiatry. It is true that many things have been placed in the classification with



dementia præcox that should not be there but this is no reason to widen the breach any further by clouding our conceptions of this disease entirely.

Perhaps it has been because of this difficulty of finding a common ground upon which the clinician and anatomist on the one hand and the psychologist on the other can meet that so little has been done to bring about a real advance in an understanding of this psychosis. It is characteristic of this to find that in a discussion of the pathogenesis of dementia præcox, there are two groups, the views of whose members must be given unquestioned weight and authority but who take diametrically opposed stands in this matter, some of them allowing for the possibility of no middle ground. In order to arrive at an understanding as to what should be the attitude of psychiatrists towards the various schools of psycho-analytic endeavor in the treatment of this disease, it seems important that those who adhere to the theory that dementia præcox is primarily an organic disease and the adherents to the dogma that it is primarily a distortion and perversion of the personality of the individual, the organic changes being secondary, should be brought to the realization of the fact that neither one of them may be right. It seems important that all fair-minded men should be willing to start in the investigation of this problem without preconceived notions. Of late years, the anatomical work done in the pathology of this disease has certainly gained very little attention in this country. This matter was recently referred to by the writer in a discussion of this question which appeared in the *Neurological Bulletin* of Columbia University (Vol. 1, No. 3, p. 106, March, 1918). I take the liberty of briefly quoting from the article mentioned so that we may be placed in the proper frame of mind towards this subject:

Meyer dismisses the neuro-pathological evidence in dementia præcox as being meager and refers particularly to the work of Kleist. He says, "The isolated facts of the frontocerebellar disorders, tremors, reflex alterations, dermatographia, seborrhœa, and the eye symptoms appear like elements in the general process but not like helps for an explanation." Referring to the histological data, chemical findings and the work of correlation of the clinical symptoms in dementia præcox with the organic changes found in the brain, the author dismisses these as being merely incidental or due to defective oxidation or possibly the consequence instead of the cause of the symptoms. Meyer emphasizes the psychobiological

viewpoint, ascribing the difficulty in this condition to habit deteriorations and tantrums which, he says, are pathologically unfavorable to the maintenance of a normal mental balance. He speaks of complexes, habit conflicts and all the other psycho-analytic mechanisms as the essential causative factors. The symptoms of the disease, he says, are due to peculiar attempts which have been made at balance and reconstruction. He admits, however, that undoubtedly a large number of cases are "beyond complete analysis and understanding."

Jelliffe' as an exponent of the view just presented by Meyer says :

I freely admit that we are still much at sea in this matter and am fully prepared to follow Meyer in part in a more functional interpretation of certain of the dementia præcox reactions.

In attempting to recognize a fundamental personality, he says :

I am directly opposed to a too dogmatic pathological interpretation. Our pathological findings may represent atrophies of unused association tracts which have resulted from the, so to speak, petrification of bad habits of mental adjustment.

Taken alone, this may appear as a definite statement of a mental attitude but in the same article from which this is quoted he also says :

So that to the more striking mental signs are added physical signs of almost as definite a character as those met with in paresis. The clinical pictures are bound to begin in a slightly different manner, according to the anatomical localization of the processes. The course will vary by reason of the same factors of variability in contact with the pathological alteration and the general end level will be reached largely as is paresis by the more or less general diffusion of the processes in the areas of special predilection.

From which we can see that this author is certainly not clear in his own mind as to the genesis of the symptomatology of dementia præcox, nor is he prepared to give the psychobiological interpretation the place of prime importance in the production of the symptoms of this disease.

Hoch' perhaps takes the most decided stand of any of these three exponents of the functional theory of dementia præcox. In the same monograph with Jelliffe and White, he says :

While these findings, upon which rests the claim that dementia præcox is an organic disorder in the same sense as is general paresis, cannot be neglected and represent a most important field for research, there is another set of data furnished by an analysis of the constitutional factors in these cases, of the development of the symptoms—data which would

seem to show that, granted all the findings of an anatomical and, perhaps, chemical nature, dementia præcox is after all not a condition which can be placed side by side with the plainly organic diseases, such as general paralysis.

The last-mentioned author is perhaps influenced in his opinion by his studies of the personality in dementia præcox, I do not wish to convey the impression that studies of this kind are not important for the understanding of the psychoses, but it may be possible that too much stress has been laid upon the presence of defects of personality as an actual causative factor of dementia præcox. The part which the individual's personality plays in this psychosis cannot be disregarded. Nevertheless, one must be cautious in assigning to this one factor the unquestioned responsibility for the production of the disease. The character of the mental reactions may be influenced by the person's make-up, which is nothing more than the sum total of the individual's experiences. Character anomalies may, therefore, determine the type of delusional trends and the content of the hallucinations. About this there can be very little question.

But it may be possible that the precipitation of these reactions, together with the entire thought content of the psychosis, is secondary and incidental to the organic changes which occur throughout the body and particularly in the brain. What is meant can probably be best brought out by reference to certain observations recently made in a personality study of 36 cases of paresis published in the *Journal of the American Medical Association* (February 16, 1918, Vol. 70, pp. 434-439), in which we were able to suggest the great part that the personality plays in the character of the psychotic reactions in paresis. The conclusion which we reached from this study was that any one of several peculiar abnormal or neurotic types of personality existing in the syphilitic individual was liable to determine the nature of the parietic psychotic reaction. Paresis seemed to be capable for our purposes of being divided into two great groups. In one, not a small group, can be placed those cases characterized by rapidly increasing organic dementia and dilapidation of person and intellect without a psychotic reaction of definite type; and a second, a larger group, in whom the actual evidences of brain destruction, as expressed by the profound mental deterioration, were not at all marked especially at first, but in whom there existed a definite

psychosis the nature of which might be either classed as paranoid, manic, depressive, euphoric or expansive. The first group was also characterized by the frequency with which physical signs of paresis were early encountered and were possessed of essentially normal, efficient personalities. Of the second group many went unrecognized until physical signs developed and disclosed the nature of the trouble. In this psychotic group the personalities were definitely abnormal. One of these cases which I reported is particularly instructive along these lines, for in one institution she was diagnosed as a case of dementia præcox, and in another she was considered to be manic-depressive insanity. It was only when physical signs in the pupils and changes in the reflexes made themselves so manifest that they could no longer be overlooked that any other diagnosis was considered. The diagnosis was confirmed by laboratory examinations of the blood and spinal fluid. Instances such as this are met, not only in paresis, but in the psychotic reactions of various types of neuro-syphilis and are highly instructive.

Schneider<sup>8</sup> has shown that in alcoholic hallucinosis definite "precipitating factors other than the alcohol are present and necessary in its production and are often reproduced in the psychosis." Kirby,<sup>9</sup> referring also to alcoholic hallucinosis, states "in nearly every case . . . one can establish that a definite emotional stress has immediately preceded the development of the hallucinosis; for instance, a threat, a quarrel, a fight, an arrest, imprisonment or some other annoying occurrence or actual cause for worry or anxiety." And in these cases Kirby remarks, "that the trend and hallucinatory content nearly always contains reference to the particular event which has disturbed the patient just before the outbreak of the psychosis." That this discussion is germane to our problem of dementia præcox can be seen from the fact that both Kraepelin and Bleuler have drawn a fairly definite analogy between the alcoholic hallucinoses and dementia præcox, although recognizing important differences, particularly in the recoverability of the former. Just as in the alcoholic cases the affects and other mental characteristics of the patient are exhibited in the delusional trends and hallucinations, so it may be in dementia præcox. The disturbing factor, whatever it may be, may act in some such manner. Hoch, Kirby and others have definitely

shown the peculiarities of conduct and peculiar mental reactions which long precede the precipitation of the actual psychosis in dementia præcox. No one has, as yet, given us even a suspicion of the nature of the causative agent in the production of dementia præcox, but what occurs in the alcoholic hallucinosis might conceivably occur with some other toxic substance in dementia præcox, the resulting psychosis exhibiting in the delusional trends and hallucinatory content the peculiarities of personality of the individual. The analogy might be drawn even closer, for many cases of alcoholic hallucinosis when they clear up or have a recurrence show definite dementia præcox characteristics. Others, of course, simulate manic-depressive reactions. It is noteworthy that in individuals exhibiting either of these two types the personalities recognized as characteristic of these psychoses have been demonstrated as having been present long before the hallucinosis; but the alcohol and the emotional upset seems to be necessary for the production of the psychosis. The alcohol, therefore, apparently supplies the toxic material which causes quantitative and qualitative changes in the brain cells which are responsible for the symptoms of disordered mental function.

The influence of the personality of the individual in producing the type of psychotic reaction, whether it be in paresis, brain syphilis, chronic alcoholic hallucinosis or dementia præcox, cannot be questioned. That these peculiar personal characteristics are the primary cause of dementia præcox any more than they are the causative factor in these other conditions has not been proved definitely, despite the writings of the gentlemen quoted, or the insistence of other adherents of the psycho-analytic schools led by Freud, Jung and Adler.

It is necessary to call attention to the work of Southard,<sup>2</sup> Nissl,<sup>3</sup> Kleist,<sup>4</sup> Alzheimer,<sup>5</sup> Sioli,<sup>6</sup> Rosanoff,<sup>7</sup> Morse,<sup>8</sup> and others in order to bring the investigator into the question of the pathogenesis of dementia præcox to the realization that there is another than the psychological aspect to the problem. It may be useful to refer briefly to their findings. The clinical findings consist of tremors, changes in the reflexes, dermatographia, seborrhœa and certain eye symptoms. These last have recently been reviewed by Hoch<sup>9</sup> and Teal.<sup>10</sup>

Hoch's review of the subject of the eye changes in dementia præcox shows, first, that they consist of the absence in a number of cases of the psycho-reflex; that is, dilatation of the pupils associated with mental activity, mental effort, affects, etc., and also in response to various sensory stimuli. Secondly change in the shape of the pupil and sluggishness to light reactions, especially in catatonic stupor. This symptom was called by Westphal catatonic stiffness of the pupil and is essentially a transient loss of light or accommodation reaction with changes in the shape of the pupils.

Abstracting the work of F. Reichmann, Hoch finds that her investigation showed 61 cases of dementia præcox with unusually large pupils and 31 with small pupils; 47 cases showed irregularities; eight cases demonstrated hippus and 30 cases presented anisocoria. She also found that in 215 cases of dementia præcox, ovarian pressure caused dilatation of the pupils 113 times, with some interference in the light reaction 29 times. The abstractor calls attention to the difference in these findings from that of hysteria. In hysteria, pupil dilatation occurs upon ovarian pressure without disturbance of the light reaction.

Teal found in 53 cases of dementia præcox dilated and tortuous veins and contracted arteries in the fundi. He also found various degrees of papilloedema. He examined the fields in 15 cases of recent development. The charts showed concentrically contracted fields for form and color with frequent interlacing of the color fields. This contraction ranged from slightly less than normal to 30 degrees.

A brief reference ought perhaps to be made in passing to the various interesting, though not conclusive, studies in metabolism and in changes of the vegetative nervous system and the glands of internal secretion in this condition.

Of the metabolism studies, that of Ellison L. Ross<sup>28</sup> in five cases of dementia præcox is picked as a type. Ross quotes Pighini and Statuti as claiming that the metabolism is not normal in dementia præcox. Finding that various authors dispute this statement, Ross undertook the study in these five cases of the total nitrogen, sulphur, phosphorus, calcium and magnesium metabolism with their partition. Without going into detail as to the methods pursued, we find that he concludes the chief changes were found in metabolism of sulphur. These changes consisted of a diminution

of the amount of total sulphate, including the inorganic sulphate both in acute and chronic cases of dementia præcox, the amount of neutral sulphur excreted being above the normal. He, therefore, confirmed the finding of Pighini. He concludes that in acute cases the patients lose their normal powers of oxidation and suggests that the same condition prevails in the chronic cases. Attention is called also to the fact that the nervous system is richer in sulphate compounds than any other of the tissues of the body and that it has a high rate of metabolism in normal conditions. Other observers, particularly W. Koch, have found that the neutral sulphate is decreased in the brains of dementia præcox patients. It may be possible to refer with some profit also to the studies of various authors of the injection of adrenalin and pilocarpin in cases of dementia præcox. For instance, Neuburger,<sup>2</sup> on the action of adrenalin injection upon the blood pressure, says that in 80 per cent of the cases experimented with the reaction to adrenalin injection is diminished or absent. This refers to the influence on blood pressure and pulse rate. The exceptions to this rule were the paranoid cases studied and the excited cases with remissions who show a more nearly normal reaction to adrenalin. The number of cases studied was 63. As controls, 39 cases of various psychoses, neuroses and psychoneuroses were used.

Walter and Krumbach<sup>3</sup> studied 18 cases of dementia præcox, four of which were chronic catatonic conditions, and three, chronic paranoid conditions, the others being more active types. They tested these cases with adrenalin, atropin and pilocarpin and found that only in the cases which showed chronic stuporous states were there any definite influences. In these cases adrenalin, atropin and pilocarpin had no influence on the blood pressure or pulse, and pilocarpin did not produce sweating. In the excited and paranoid conditions, the findings were inconclusive.

Brief reference might also be made (Dercum<sup>4</sup>) to the fact that the thyroid gland has been found enlarged in many cases of dementia præcox by various authors and that the body weight is generally below normal in this condition.

Alzheimer<sup>5</sup> definitely states that he is convinced that dementia præcox is an organic disease of the brain and he is inclined to regard the anatomical changes as definite. These changes consist of lesions in the second and third layers of the cortex characterized by sclerotic nerve cells, infiltration of cells with lymphoid sub-

stance, disappearance of nerve elements, gliosis and the appearance of amœboid glia cells. Alzheimer points out these findings were particularly marked in the small cell layers of the cortex. Upon these findings, Kraepelin<sup>2</sup> explains the preservation of memory and acquired knowledge on the theory that these have their seat in the deeper layers of the cortex. To the second and third cortical layers which are affected in this disease, Kraepelin ascribes the function of the liberation or translation of perceptions into concepts, of sensations into feelings and of impulses into activity of the will. Such an interpretation, if found to be based on fact, would exactly explain the symptomatology of dementia præcox.

Southard's<sup>3</sup> work, calling attention to the satellitosis and macroscopic areas of palpable gliosis with microgyria and visible atrophy and the microscopic evidences of sclerotic changes in nerve cells in 89 per cent of the cases examined is too well known to be more than mentioned.

Sioli<sup>4</sup> found in every one of 20 cases of undoubted dementia præcox destruction of nerve tissue and disarrangement of the normal layer formation of cortex cells, degenerative products in the perivascular and lymph spaces and amœboid cells, together with gliosis in the white matter and in the deep cortex layers.

The findings of Rosanoff,<sup>5</sup> which led him to make the unequivocal statement that mental deterioration in dementia præcox goes hand in hand with brain atrophy, are also so well known that they need no more than be mentioned.

Because of the possibility that some organic basis may be found for the most striking, though usually late, symptom of dementia præcox, the work of Morse<sup>6</sup> is interesting. The dissociation between the retained intellectual functions and the emotional deterioration has a suggested explanation in her findings. Her cases died sufficiently young to make it possible to exclude the ordinary senile and arteriosclerotic changes found in brains at autopsy. The neuroglia in the optic thalami was especially investigated. Seven cases of other mental disorders were used as controls, including two cases of arteriosclerosis and senile dementia. She found increase of neuroglia, diffuse and focal, in one or more of the thalamic nuclei, cerebral cortex and in the white matter of the brain. The control cases showed none of these changes excepting the usual peripheral gliosis and perivascular increase in the



senile and arteriosclerosis cases. The writer makes the statement that "thalamic gliosis occurs more frequently in dementia præcox cases than in those with other psychoses who died at about the same age."

What bearing this finding has on the problem of dementia præcox is suggested by analogy with numerous clinical observations made in other conditions, particularly pseudo-bulbar palsy and progressive lenticular degeneration. In these conditions, the lack of emotional control is a prominent symptom and is generally ascribed to involvement of the thalamus and other basal ganglia. This observation has been frequently confirmed by various neurologists. It is not uncommon to see cases of pseudo-bulbar palsy with completely retained mental faculties who laugh immoderately or cry uncontrollably with very little or no stimulus. The similarity between this symptom and the same condition so often met with in dementia præcox makes a striking analogy. The perusal of a review of the subject of pseudo-bulbar palsy by Tilney<sup>2</sup> is, in this connection, extremely interesting. That the analogy should not be drawn too close, however, must be mentioned, because Tilney found that the lesions in cases of pseudo-bulbar palsy were in a majority of cases multiple and occurred in the projection systems as well as in the basal ganglia or the pons or medullary nuclei. A closer analogy can be drawn in the cases of progressive lenticular degeneration described by Wilson.<sup>3</sup> Concerning the matter of the mental symptoms of this disease, Wilson says, "It is a noteworthy fact that some form of mental change or impairment is specifically referred to in at least eight of the twelve cases; its importance, therefore, must not be underestimated." Again on page 447 he says "If the term 'dementia' is to be employed to characterize them (the mental symptoms), it must not be forgotten that this dementia is decidedly limited. . . . It is just in the ordinary dementia of senility and to a less extent in dementia præcox that these symptoms are most common. . . . Hence, the term 'dementia' is really not appropriate." He refers to the absence of disorientation of time, place and person and points out that the dementia present in his cases cannot "be likened to the steady mental involution of senile dementia or of dementia paralytica," and further says that, "it can be readily distinguished from dementia præcox. The mental symptoms are a lowered

capacity for retaining impressions with a constriction of the mental horizon. The powers of perception and recognition are good. There are no delusions or hallucinations." He refers to these patients as being "easily tickled, pleased and amused without insight into their condition, for their cheerfulness is incompatible with knowledge of the seriousness of their illness. . . . The patient seems to be unable to deliberate or pass judgment on what is presented to him." Regarding the involuntary laughter or crying, Wilson says (page 472) that the association of these emotional states with the basal ganglia has long been recognized and he refers to their incidence in double hemiplegia and pseudo-bulbar palsy and even in simple hemiplegia. He further says, "On some occasions at least the patients did not appear to express the emotion which their musculature seemed to express." Despite the fact that Wilson says that these symptoms can readily be distinguished from dementia præcox, their striking similarity to the late symptoms of this disease can readily be appreciated. Reference to this subject may be concluded by drawing attention to the pathology of this condition which seems to be limited to a symmetrically bilateral lenticular degeneration, particularly of the putamen. The globus pallidus, caudate and some of the fibers of the thalamus which come from the corpora striata are often involved. The extent of the involvement of the thalamus appears to be more marked in some cases than in others but these striothalamic fibers regularly show a secondary degeneration.

No attempt is made here to draw an analogy between dementia præcox and affections of the basal ganglia. I simply desire to point out that the anatomical changes which seem to have been found in dementia præcox by Kleist, Nissl, Alzheimer, Southard and Morse are capable of explaining at least some of the characteristic symptoms of dementia præcox. In the presence of such evidence as these investigators present, it would be extremely unwise to take a decided stand for or against the organicity of this disease. Of late years some teachers of psychiatry and many writers on this subject have been too prone to overlook the possibility that psychobiological interpretations and purely psychological explanations of the pathogenesis of this condition may not be the only considerations possible. It seems to me that the writings of Freud, Jung, Adler and others who are responsible for

this state of affairs have retarded investigation of other phases of this important problem. What can be done to bring our attitude of this matter to a state where anatomopathological and physiological investigations will replace dogmatic, empirical, psychological explanations? It seems that the first desideratum is to demonstrate the falsity or the correctness of the stand that the psychoanalytic viewpoint has solved the problem. The best method to determine whether this disease is primarily a functional one and dependent on improper mental habits or perversions of the sex instinct with conflicts arising therefrom is to apply the therapeutic test. If this is true then the principles of psychoanalysis as laid down by the Teutonic writers, if applied to early cases of dementia præcox, should result in cures, or at least prolonged remissions, with more or less perfect adjustment of the individual affected. Just as unhelpful as is the attitude of those who refuse to concede the possibility of a causative influence of the organic findings in the development of this disease is the attitude of those who refuse to give any part in the production of the disease picture to psycho-biological influences. Occupational, educational and custodial care have resulted in a discouragingly poor percentage of recovery in dementia præcox. Let us consider giving a free hand to competent persons so that they may practice the principles of psychoanalysis and apply them to sufferers from dementia præcox under supervision in our state hospitals and sanitariums. Before doing this, however, the psychoanalysts should be prepared to investigate these cases in the broadest way, taking into consideration all the available data. They should be prepared to give us information on the part that all the instincts play in the synthesis of dementia præcox, because the true psychoanalyst does not limit himself to a consideration of the sex instinct alone. The matters discussed by Trotter concerning the Herd Instinct and principles of masculinity-femininity and the masculine protest of Adler, together with the broader aspects of the libido and life interest of Jung, and finally the investigations of the sex instinct according to Freud should all play a part in these investigations. If early cases of dementia præcox are referred to psychoanalysts and they are given unlimited opportunity for investigation and attempts at bringing about adjustment, we must then be willing to abide by the results. No one has yet given statistical data of a large number of cases treated by such psychoanalytic methods. It is high time

that this should be done. The suggestion is made that psychoanalysts be given in various parts of the country a number of cases sufficiently large to permit of fruitful observations and that in three, four or five years they be required to publish their data in statistical form for consideration. The cases should be undoubted examples of dementia præcox, presented at staff meetings or after consultation, and standardized for diagnosis according to the conceptions of Meyer, Kraepelin and Tanzi. They should be, as Tanzi<sup>28</sup> says, "patients who present the fundamental symptom of dementia præcox; namely, stolidity of conduct." Concerning the diagnosis, Tanzi further says, "that whatever may be the clinical variety to which his malady belongs, the patient suffering from dementia præcox displays the disorder of his intelligence not so much by what he says and thinks as by what he does; even when he expresses and seemingly thinks something contradictory, absurd or foolish, as often occurs, the unprejudiced observer easily perceives that the patient is not faithfully conveying his own thoughts, but is to all appearances falsifying them purposely, either from ostentation, as a joke, or owing to an involuntary treachery on the part of the volitional function." These disorders of the will and the emotions are the *sine qua non* of dementia præcox.

The views of Kraepelin<sup>29</sup> on this point may be worthy of attention because psychoanalysts have been too prone to a loose interpretation of what we mean by dementia præcox. Despite the fact that we must admit that dementia præcox has no absolute clinical, pathological or anatomical signs, it is just these mental characteristics which are definite. Kraepelin states that "this peculiar and fundamental want of any strong feeling of the impressions of life, with unimpaired ability to understand and to remember, is really the diagnostic symptom of the disease we have before us." Again on page 26 he says, "We have a state of dementia before us in which the faculty of comprehension and the recollection of knowledge previously acquired are much less affected than the judgment and especially than the emotional impulses and the acts of volition which stand in close relation to those impulses. . . . They are invariable and permanent fundamental features of dementia præcox, accompanying the whole evolution of the disease." These matters, which are clear to every one of us, seem to have es-

caped the psychoanalysts. I have carefully searched the literature and the looseness with which they couple the neuroses, the hysterias, the compulsions with this distinctly different mental state is something which should not be allowed to continue without criticism. If psychoanalysts will accept for experimentation cases showing these mental defects then in all fairness we should allow them a free hand to demonstrate their principles. If, after application of psychoanalytic methods in a considerable number of cases of very early dementia præcox, they fail to disclose their value, it may then be possible that psychiatrists in this country will throw off the shackles that have been impeding progress in the elucidation of this problem and that medical men will return to anatomical and physiological investigations as an aid to its solution. We must have definite scientific data and not beautifully descriptive systems of philosophy from our psychoanalytic friends, if they are to help us in this particular problem.

An instance of how far the pendulum has swung from a consideration of the medical aspects of dementia præcox to the purely psychological can be had by a scrutiny of what appears to be at present the most popular of these psychoanalytic viewpoints. I have reference more particularly to the work of Adler<sup>1</sup> as expressed in his book "The Neurotic Constitution." The number of unconfirmed views and unsupported statements presented by this author as facts cannot be allowed to go unquestioned. Some assertions made in this book are characteristic of a great deal of the psychoanalytic literature and this brief, critical review is undertaken as a check on what we regard as the baneful influence which this particular work has had on the minds of a great many of those interested in psychiatric subjects. Particular reference is made wherever possible to his discussions of dementia præcox.

Referring to the instinct that the child has of obtaining security by striving towards a fixed point where he sees himself greater and stronger, where he finds himself rid of the helplessness of infancy, Adler says (page 53), "The qualities of greatness, power, knowledge and ability are constructed in the image of father, mother, older brother or sister or some hero, etc. These stand like idols of clay and they receive from the imagination of mind the force which afterwards reacts on the psyche which has created them. In so far as the child is able at all times to free himself

from the bonds of his fiction, these artifices of thinking show the only difference from the manner of thinking in paranoid and dementia præcox conditions." The main difference is, therefore, according to this conception, that the normal is able to free himself from his fancies and return quickly to reality, whereas in the case of the psychoses mentioned, this is not possible. But, as Adler says, "there is this similarity of adherence to a fiction in normal persons, neurotics and the insane." On page 76, making reference to the "psychotic individual," Adler takes issue with Freud, whom he says stopped at the point "of discovering the actual or possible sexual formula in these symbols and has not pursued their further elucidation into the dynamic eventuality of the masculine protest of striving upward." His philosophy of the neurotic constitution is thus summarized and consists of what he designates as the guiding line or striving upward manifested by the "masculine protest" in individuals whom he calls somatically inferior. This, in a few words, is his conception.

On page 92, Adler makes the statement that the child (meaning probably the neurotic child) brings forward into consciousness an acute sense of inferiority which is permanent and depends on the presence in such individuals of inferior organs, and that as a result of this consciousness of inferiority, a formula is established by which the neurotic strives to become master of the situation. These attempts at compensation of physical inferiority lead to the symptomatology of the neuroses and psychoses. According to Adler, all the symptoms of these conditions can be explained on the grounds of a more or less conscious striving to hide and over-compensate this inferiority. He says that in the organs which fall below the normal standard are to be seen the more frequent referred somatic complaints. Therefore, it is said that these inferior, neurotic individuals, in order to hide their inferiority, set an unusually high goal which it is never possible for them to attain. On page 95, he says, "Nervousness, by preference, utilizes organic defectiveness, the infantile defects, the sense of ill-health in general on the one hand, for the purpose of securing the ego-consciousness against the requirements of parental authority, usually by means of a stubborn revolt. . . . Indeed, the neurotic individual often seeks minor defects, even brings them about artificially, or assumes dangerous outlooks in order thereby

to justify his neurotic acts and caution." To this fiction which Adler calls the masculine protest he ascribes everything in the neurotic constitution. In differing from the Freudians, he says (page 106), "That a further pursuance of the matter leads irrevocably to a realization of the untenableness of the libido-theory, to a doing away with the sexual etiology and to an understanding of the neurotic sexual conduct as a fiction."

In this way Adler throws a sop to those who object to the predominance of sex in the Freudian theories and explains the sexual conflicts of the neurotic on the theory that they are part of the means by which these individuals obtain the mastery over their environment. According to Adler, therefore, these sex matters are not the causative factor in the development of the neurosis, but are only one of the means used by the neurotic as an aid in making the masculine protest. This twist in the presentation of the sexual side of this question does not prevent the greater part of the pages of this book from being given over to a full discussion of the sex problems which have been much more conclusively and convincingly set forth by Freud and others. When one examines the evidence on which Adler bases his ideas that the neurotics are possessed of inferior organs, we find that he points as confirmation to ulcer of the stomach, appendicitis, cancer, diabetes, liver and gall-bladder disease, as evidences of such inferiority. Why he omitted typhoid fever from this classification it is hard to understand unless one considers that possibly Adler has met and been conquered by the bacillus typhosus. On the same page (122) one finds further evidence of the extravagant lengths to which Adler carries his unconvincing reasoning. He says that a number of neurotic symptoms such as obstipation, colic, asthma, vertigo, vomiting, headache and migraine are symbolic of "a voluntary but unconsciously co-operating activity of anus contraction and abdominal pressure," which are used as an aid by the neurotic for domination. In these individuals Adler says that greed for gold and power are in the foreground of their ideals, which is nothing more or less than a repetition of the ideas of Freud and Jung, who associate these traits with what they call the anal neurotic types.

It is on such flimsy and ephemeral data that Adler builds his conception and it is upon principles such as this that a great many

attempt to explain the development of dementia præcox, various other psychoses and neuroses. It is with an idea of presenting to these individuals and to certain medical psychologists the possibility that they are in error that this paper is primarily written. It is also hoped that we may give them a definite opportunity to prove to us the truth of their data in a scientific way.

Further reference to the work of Adler shows that he regards certain purely mechanical pathological conditions as evidences of inferiority. Particularly important in this regard does Adler place the inguinal hernia (page 145) which we have always understood to be a rather innocuous, mechanically produced condition. The idea that inguinal hernia is an evidence of organic inferiority will certainly be interesting. The idea, however, that individuals possessing this condition have a (fatal) determinant of neurotic manifestations will perhaps be startling. Even more startling than this will be the statement made on page 318, "I have in various instances learned to recognize this connection with epilepsy, sciatica, trigeminal neuralgia. I have proved that these latter conditions were psychogenic in nature and originated whenever strong securities were demanded." In this connection the author also mentions migraine. These conditions, which we have always felt had a pathological foundation, are ascribed by Adler as symbolical, more or less voluntary, aids in the struggle of neurotics against the feeling of being beneath or as a struggle against femininity—or as an expression of the masculine protest.

As against the correlations which Southard, Kleist, Kræpelin, Alzheimer and others have attempted to make between the symptomatology of dementia præcox and the pathological findings, we have Adler's views on the pathogenesis of the delusions, hallucinations, attitudes and other symptoms. On pages 234 and 237 we find this explanation of the origin of delusion and hallucination. Speaking about a patient whose analysis he presents, he says, "The essential part of a psychosis depends upon a dogmatic anticipatory representation of a fear or a wish, which the craving for security offers for the better testimony in a phase of great insecurity, in strong dependence on the fictitious guiding line for the conservation of the ego-consciousness." Explaining the symptom of tearing off the clothes which so many excited patients have, he says (page 237) that they "tear the clothes from the



body as though they would divest themselves of the modesty which they regard as feminine, as though they wished to make a parade of fictitious, large, masculine, genital organs and thus belittle others." On page 266, concerning hallucinations, he says, "Hallucinations as well as dreams are, like other tentatives of the psyche, fitted for finding the way which leads to the maximation or preservation of the ego-consciousness. In it are reflected the faiths, the hopes or the fears of the patient." On the bottom of page 267 he says, "In paranoia and dementia præcox, the emotions leading to the masculine protest disguise themselves in the form of hallucinations and assure the psychotic scheme through their acoustic or visual complement."

If these explanations of the production of delusions and hallucinations are true, it is of the utmost importance that this fact be demonstrated to the satisfaction of all psychiatrists. If they are found to be true upon investigation, then a good deal of the work which is being done in neuropathology may just as well be stopped. These matters must not be settled by acquiescence in unsupported statements such as these. Nowhere in this book does Adler give any idea of the results of his psychoanalytic treatment. It is essential that a sharp therapeutic test be made of these matters and that careful records be published, not only of the methods followed but also of the results obtained. The fallacy or the truth of statements like these must be settled soon if psychiatry is to make any progress in solving the problem of dementia præcox. Concerning the symptoms of stereotypy and the delusion of grandeur in a catatonic, Adler says (page 276), "Stereotypies were manifested, among other ways, by an occasional upright position of the body and by holding the head high, a motion which I was able to interpret as symbolic, as a phantasy of the erection of the male organ."

Not referring for the moment to the intensely boastful "I" of the author (we are sure many other psychoanalysts are capable of making the same deductions in like cases), I should like to inquire whether everyone is prepared to accept this explanation of stereotypy as against the possibility that it may depend upon changes in the cortex of the cerebellum, the dentate and other cerebellar nuclei and their connections with the basal ganglia, the cerebral cortex, the spinal cord and anterior horn cells.

Of the various psychoanalysts in this country who have been attempting to find a middle ground upon which views such as those expressed by Adler and the views of those who hold to the theory of organicity can meet, William A. White of Washington is probably the most prominent. Dr. White has written the introduction to Adler's book. He dilates in this introduction on the healthy tendency exhibited by Adler in approaching his subject from the organic rather than the functional side. I am afraid that Dr. White will not endorse at least one of Adler's views. In this paper I have deliberately drawn several analogies, particularly one between the characteristic dissociation of the mental with the emotional reactions as it exists in dementia præcox with the same sign exhibited in pseudo-bulbar palsy and other diseases of the basal ganglia. Concerning reasoning by analogy Adler<sup>1</sup> says that it is very important in the development of the neurotic constitution and is a characteristic of the general inferiority of the neurotic psyche. White<sup>2</sup> says that "reasoning by analogy is not only a legitimate form of reasoning but it is the best of all reasoning." Agreeing with Dr. White are Jung's<sup>3</sup> views on this subject. It is only an instance of the danger of accepting without question the views of some exponents of psychoanalysis, that even in the camps of the most prominent of them, such wide differences of opinion are found about so important a point. The entire subject of symbolism on which the whole fabric of psychoanalysis is built is admittedly done by analogic thinking. Yet we are told by Adler that thinking by analogy is a trait of the neurotic, therefore, an inferior psyche.

In conclusion, it is my opinion that a decision of the questions herein discussed must be soon attempted. The only method available is to apply the therapeutic test to the principles laid down by psychoanalysts. On the other hand, we must require carefully kept records and published scientific data with tabulated results. If, after ample opportunity for investigation, they fail to give us this data, we then must regard psychoanalytic principles as they relate to the study of dementia præcox as impossible of application and confine ourselves to anatomical, pathological and physiological investigations as a means of discovering the pathogenesis of dementia præcox.

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## INTERPRETATION OF THE FUNCTIONAL NERVOUS DISEASES AT THE PHYSICOCHEMICAL LEVEL.

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Nervousness, like rheumatism, has always been a diagnostic haven of refuge from our ignorance of the real conditions of suffering humanity. As the study of focal infections has destroyed the rheumatic rendezvous, it seems that the interpretation of the functional nervous diseases at the physicochemical level will dispense with "nervousness" and other ancient descriptive terms.

The greatest criticism that the world can make against the medical men of to-day is for their neglect of the study and interpretation of human conduct. Our progress and achievement in the fields of pathology, surgery, bacteriology, physical diagnosis, hygiene, sanitation, immunology and other branches of medicine, have received the praise and blessing of a truly grateful world, but why the neglect of that vast army of sick and unhappy human beings in whom we, as physicians, after a thorough and careful examination, can find absolutely no evidence of organic disease?

Call them neuropaths, psychasthenics, hysterics, neurasthenics or border-land mental cases, it makes no difference what, such designation will not allay their fears or produce sleep, increase their weight or make them capable and efficient in performing their necessary duties. In our failure to regard the individual as an adaptive organism, capable of thinking, feeling and acting in response to his own impulses, we have been responsible for the birth of Christian Science, divine healing, osteopathy, chiropractic and many other forms of pseudotherapy.

Now it should be comprehensible why at least 50,000,000 people refuse our services and seek to worship at the shrine of bastard "opathies." The interpretation of symptoms of the functional nervous diseases at the physicochemical level assumes the practical application of the rational division of the study of nervous diseases as suggested and developed by Drs. White and Jelliffe in their most valuable and instructive text-book on nervous and mental diseases. For the psychobiological conception of the nervous system, I am indebted to a most valuable and extraordinary

book entitled "Man: an Adaptive Mechanism," written by the celebrated Cleveland surgeon, Dr. Crile, who developed his kinetic system as a result of his investigation and experiments on the causes of surgical shock and its prevention by anociation.

Geologists have been enabled by their study and investigation of the earth's surface, its formation, and the character and content of its strata at different levels, to interpret and read the history of its development and the changes which have resulted from its contact with the elements which surround it. Likewise, the biologist has developed the phylogenesis of man from the study and investigation of the organs and the mechanisms of the systems of environmental adaptation.

The acceptance of the theory of the divine plan of evolution, has, however, disposed of the last barrier to an impersonal consideration of the human body as a biological unit. It is now as reasonable to explain a muscular reflex, an emotion or an internal secretion by its necessity in life of the individual as to explain the webbed feet of the duck or the sharp teeth of the cat. In like manner, those functions that have been defined as physical, mental, moral, emotional and social, have been determined by factors in an hostile environment during the many ages of the struggle for existence.

In order to understand these adaptive processes in man, we must divest the organism of all powers of action except that of response to stimuli, and regard every vital manifestation as one phase of the organism's adaptation to environment by the transformation of potential energy in response to specific stimuli. Man is thus essentially a transformer of energy which is derived from the environment and ultimately returned to the environment ; so the reactions of man are the inevitable results produced in a sensitive structure by an activating environment.

The special mechanism of man's environmental adaptation is his nervous system, which coordinates each part of his body with every other part by the mechanism of the vegetative nervous system, ably assisted by the internal secretions, and it also brings the body as a unit into relationship with the environment by the interaction of the vegetative, kinetic and the cerebrospinal systems.

Now if we consider the human body as a biological unit, we must admit that it is made up of systems which have been evolved

for definite biological needs, and these systems continue to respond to the necessary functions of life and health. The forthcoming brief description will suffice for present needs:

- (a) The digestive system converts crude food into blood and tissue.
- (b) The circulatory system distributes food elements and removes waste products.
- (c) The respiratory system eliminates poisons and purifies the blood by the exchange of gases.
- (d) The urinary system removes and eliminates the end products of tissue oxidation.
- (e) The perspiratory system regulates surface temperature and eliminates waste products.
- (f) The reproductive system serves the biological necessity for the propagation of the race.

Now it seems to be an established fact that the vegetative nervous system controls the functioning of all these adaptive systems, as is stated by Jelliffe and White:

The vegetative nervous system consists of those structures which supply, by afferent and efferent pathways, impulses to the special sense organs, smooth muscle fibers, and all those automatically acting organs, such as the heart, lungs, intestines, genital apparatus, blood vessels, excretory glands, skin, and organs of internal and external secretion, such as the liver, stomach, pancreas, intestinal glands, thyroid, thymus, adrenals, parathyroids, hypophysis and epiphysis, etc., respectively. All these structures are constantly in function and their disturbances are manifold; either through emotional activities, as seen in many neuroses and psychoneuroses, or infections and intoxications.

Now it seems that the adaptive systems are wholly devoted to the satisfactory adjustment of the internal environment, and consequently generate potential nerve energy which is to be transformed into kinetic energy by another greater system for the instinctive purposes of self-preservation and reproduction. This system Dr. Crile has evolved, and proposes that it be called the "kinetic system."

He says that the principal organs comprising the kinetic system are the brain, thyroid, adrenals, liver and muscles. The brain is the great central battery which, being driven by the environment, *also* drives the body; the thyroid governs the conditions favoring tissue oxidation; the adrenals govern the immediate oxidation

processes ; the liver fabricates and stores glycogen and is the great neutralizer of the acid products of energy transformation ; and the muscles are the final converters of latent energy into motion and heat. Now, then, no individual who has inherited a well-balanced vegetative nervous system need fear the development of the functional nervous diseases, unless, by some means, the vegetative nerve supply of any one or more of his adaptive systems become involved. Then, of course, it would present the same organic functional incapacity for adaptation as if it were structurally inferior.

Given an individual who has inherited or otherwise obtained a vegetative nervous system that is structurally inferior in its supply to one or more of the adaptive systems, then we can proceed to inquire as to why these unfortunate people develop the symptoms of the functional nervous diseases.

In the first place, there never was and never will be two nervous systems exactly alike in structural perfection or efficient physiological functioning, to either internal or external environmental stimuli, so naturally each case becomes an individual problem for interpretation and adjustment.

Accepting the kinetic system as the biological mechanism by which the individual transforms potential into kinetic energy for the satisfactory adjustment of instinctive inhibitions and environmental demands, it is reasonable to suppose that the kinetic system performs its function as a result of emotional stimuli upon the vegetative nervous system expressed at the physicochemical level. In explanation of the emotional stimuli, it may be said that they represent the phylogenetic equivalents of muscular integration of the basic emotions of fear, anger and love.

Dr. Crile, in his explanation of the gross phenomena of the emotions, says that man, under the stimulus of strong emotions, possesses and exhibits an extraordinary amount of physical strength, and this may be explained by the biological fact that fear and anger drive certain systems and inhibit others, so that every particle of available energy is concentrated upon the fighting and escaping mechanisms. The advantage of this power in our ancestral struggle for the survival of the fittest is obvious, but that the tendency should persist to-day, in spite of the disappearance of the stimuli for flight and combat, is our unfortunate heritage of phylogenesis.



Notwithstanding the fact that man, by harnessing the forces of nature, and through social coordination has vastly improved his methods of acquiring food and avoiding danger, his body still responds to threatened moral or financial disaster as if the primitive need for physical flight or combat still remained. It makes no difference whether the cause of fear be religious, moral, social or financial, the exhaustion of nerve energy is the same. As the emotions of fear, anger and love express the motor acts of flight, attack and conjugal embrace, so the mental states of anxiety, disappointment, sadness, despondency, grief, despair, envy and jealousy, may be interpreted as chronic forms of these major activations.

If the environment by specific stimuli drives the brain, and the brain by specific response through the adaptive systems drives the body, then in order to satisfactorily solve the problem of nervous exhaustion and be able to interpret its innumerable clinical manifestations it is obvious that we must look to those adaptive systems of biological adjustment that sustain the wear and tear of our ever-increasing activities, which result from the struggle to live, to succeed and to be happy.

When the emotional stimuli are permitted by a healthy body and a tolerant environment to perform the muscular activity for which they were initiated, then we have no extra stress upon any of the adaptive systems. So long as muscular exertion or its equivalent is equal to bodily integration, there is produced normal fatigue, but suppose that the structural inferiority or functional inefficiency of one or more of the adaptive systems should partially or completely inhibit the physiological discharge of nerve energy, there naturally occurs a continuous bombardment of the environmental adaptive systems, which, if prolonged, will produce by the process of summation and the by-products of incomplete oxidation, the objective and subjective symptoms of the functional nervous diseases.

The recent study and interpretation of the symptoms and the causes of shell shock and the war neuroses has greatly added to the mechanistic conception of these diseases.

If we investigate the cerebrospinal nervous system at the reflex level by the routine tests of the ordinary neurological examination, we can usually find certain signs or symptoms, either objec-

tive or subjective, which will point with a reasonable degree of accuracy to the region involved and give some assurance as to the character of the affected tissue. It seems to me that no amount of investigation at this level will explain the symptoms of the disorders of the adaptive system of environmental adjustment.

With the highest regard for the service once rendered by the traditional grouping and descriptive classification of the functional nervous diseases, I do respectfully solicit your interest and worthy consideration of the organic functional nervous diseases as expressed at the physicochemical level.

# THE MENTAL DEFICIENCY SURVEY OF KENTUCKY, 1917.

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The National Committee for Mental Hygiene sent the writer in January, 1917, to act as scientific adviser to the Kentucky Commission on Provision for the Feeble-Minded, which had been appointed by Governor A. O. Stanley in accordance with a joint resolution of the General Assembly. By the terms of this resolution, the commission was required to report to the governor June 1, 1917. In these few months at our disposal we had to study the financial situation in the state and the history of Kentucky legislation for dependents as well as the actual conditions of the mental defectives in the state.

## OUTSTANDING FACTS IN THE SITUATION.

A number of outstanding elements, some of them quite peculiar to the state, impressed themselves upon the outside student of the situation from the start.

1. Of first importance was the fact that the state, constitutionally unable to borrow money, had been compelled to issue promises to pay to the extent of two and one-half million dollars. These obligations were outstanding, and the state expenditures were annually about one-half million in excess of income. A tax commission to propose a system of revenue providing for state expense was under appointment, and was expected to report to a special session of the legislature.

In view of this condition of the treasury of the state it was clearly our business to devise a means by which money already being spent year by year upon dependents and delinquents, at the same time defective, could be diverted to the care and treatment of these same persons as mental defectives.

2. Under an ancient and antiquated institution known as the "pauper idiot act," the state was paying each year from the state treasury, seventy-five dollars (\$75) to each one of more than

twenty-two hundred (2200) presumably mental defectives. This represented an annual outlay of more than sixty-five thousand dollars (\$65,000). It was paid to committees for these persons, and the persons themselves lived with their families, were boarded in private homes, or lived at county poor farms. The law dates from the third year of the commonwealth, 1793. At first both "lunatics and idiots," to use the phraseology of the statutes, were subject to this arrangement. When the state established a hospital for the insane, idiots were admitted as the insane. But it seemed to work an injustice to the merely weak minded to take them away from their families, and when families were willing to care for them at home, provision was made for the family to be paid an amount each year equal to what it would cost to maintain them in a state institution. Through all the increasing knowledge of 124 years, as to the special training necessary for this class and the need for special care and custody, this institution has stood in Kentucky as a protective inducement and aid in the propagation of the feeble-minded.

3. A school for the feeble-minded, the Kentucky Institution for Feeble-Minded Children, was founded soon after it was demonstrated by Seguin that persons of this class were capable of training. This school at Frankfort was, however, very true to the training idea. The law provided that only children capable of training in reading and writing or in some useful work and between 6 and 18 years of age should be admitted, and that they must be discharged when capable of earning their livelihood, or, at the latest, at 18 years of age for girls, and 21 for boys. This institution, therefore, provided no custody of these perennial children during the years when they were most likely to become parents of other feeble-minded state charges.

4. The state owns and operates three hospitals for the insane. One of these, as already mentioned, was the second state-owned hospital for the insane in the United States. Many feeble-minded and epileptics, under the circumstances, would probably be found in these hospitals.

5. The Kentucky Children's Home Society, while primarily a child placing agent, maintains a home and training school in Louisville. There were about 130 children in residence. Such groups of dependent children are apt to comprise numbers who are mentally defective.

6. The state schools for the deaf and the blind, at Danville and Louisville, respectively, would be expected to have upon their rolls other children who were mentally defective, as well as deaf or blind.

7. The Houses of Reform (industrial school for boys and girls) near Lexington, with a population of over 400 would doubtless furnish some instances of delinquents who were defective, and for that reason incapable of socialization and reform.

8. The Louisville Industrial School, with about the same population, might be expected to furnish other illustrations of misdirected effort in constructive citizenship.

9. The two penitentiaries at Frankfort and Eddyville, likewise probably hold as residents some mental weaklings who can only be expected to follow recidivistic careers while attempts at their reformation follow the ordinary treatment in such institutions.

10. The county jails and the county poor farms, being the local harbors for delinquents and dependents, would afford numerous instances where the primary cause of the person being a public charge lay in his inadequate mental endowment.

11. The commitment law providing for the commitment of the insane and of feeble-minded children and for the pensioning of pauper idiots is an ancient form of trial by jury. This is subject to such abuse that its workings are really farcical. In nine-tenths of the cases tried for lunacy, I am reliably informed, the accused does not appear before the jury as required by law, but is certified by two physicians as unable to appear in court. Physicians would better be given the duty and responsibility of making the diagnosis and presenting the evidence in court in all cases of mental disorder and mental deficiency.

#### RESULTS OF CLOSER INVESTIGATION OF SOME OF THESE CONDITIONS. SOME INSTITUTION SURVEYS.

1. In order to criticise the Pauper Idiot Act from the point of view of the actual facts of its workings in the field, the state pensioners in four counties in various parts of the state were visited in their homes. By virtue of the jury system of diagnosis, one would expect to find many pensioned as feeble-minded who are not so. Of the 82 persons thus seen, each one of whom was

drawing \$75 a year from the state treasury as a pauper and an idiot, two were clearly insane and not feeble-minded.

Five of them were actually earning enough to provide themselves with food, shelter and clothing. Many others have been purposely brought up in idleness in order to demonstrate to juries that they cannot earn their own means of livelihood. Concerning the home training of such persons, it is a patent fact that their own more or less defective relatives are the poorest persons possible to develop their subnormal minds.

Thirteen of the 82 cases were quite clearly epileptics. The conditions of such persons in homes are often distressing. They are not getting any treatment to alleviate the condition, and the personal care is often quite inferior to what a properly equipped institution would give them.

Some of those who are aments of the low grade moron level, are quite without family ties and are farmed out to anyone who will undertake their maintenance for the state allowance. Two brothers, aged about 28 and 35, were thus kept in a small one-room cabin by a man who was no kin to them and interested only in what he could make out of the allowances. They had been at the county poor farm, and had run away. A state colony in which they would have come to feel some proprietary rights, would have made them happier and somewhat useful. Many girls and boys are a great care in their own homes, tend to run away and get into mischief, and do not work, whereas with institution training they would be contented and of considerable use to the community.

Three of the 82 were deaf, and two were blind.

Two boys were found in one family, 12 and 18 years old, both of the idiot level. Another brother, who was also on the state, died the year before. The mother of these boys was an epileptic. She had two brothers who were "helpless." She had been married four times and has had defectives or epileptics by each marriage. Her grandmother had three feeble-minded children. Now she is married to a first cousin whose father was a deaf mute. Such a tainted germ plasm a state and community should be able to control. The plan of state pensions to the afflicted is farthest from an approach to control. It rather encourages the multiplication of such stock.

One "boy" of 23 years, but with a mind development of about seven and a half, had married while receiving state aid in one of these counties. He was well developed physically, but quite empty headed. Another girl had gone to an adjoining county and was not seen. Her mother was dead. A responsible and well-informed female cousin who had kept the girl with her for a time, was much concerned lest she should become a mother. She spoke of her as physically attractive, but quite empty headed and irresponsible. The \$75 which the state pays on account of this girl's mental defect every year is no guarantee she will not become a mother of defectives. It, in fact, makes it more likely that she will.

One fundamental objection to the plan of state aid in their homes to mental defectives is the petty graft to which these pensions are subject all along the line. In one populous county, a court attaché makes a very substantial income from discounting these state pensions. As much as 40 per cent of the pension is given sometimes by the none too strong-minded relatives of a state pensioner for the payment of some real money. In one county the clerk of the circuit court is himself committee for more than 15 of the 30 odd pauper idiots of that county. This clerk also has a grocery store at the county seat, and it was remarkable how many of the committees when asked how they got their \$75 each year, said they took it out in groceries at the store of the circuit court clerk. A county poor farm was found where there were 12 inmates. Three of these were on the state pauper idiot list and the keeper was committee for them. This money he put in his pocket as part of his salary for maintaining the farm. His wife naively pointed out three others whom they hoped to have put on the state list at the next session of the court and thus double the revenue from the state treasury.

2. In order to obtain a first-hand acquaintance with the nature and extent of the county care of mental defectives the county poor farms of 15 of the 116 counties of the state were visited. There were 422 inmates at the times of these visits, April and May. Populations at this time of year are considerably reduced. Many presumably feeble-minded women of child-bearing age were heard of who had recently taken leave from their winter shelter. Nearly every one of the resident inmates was interviewed. Under the conditions it was not possible to make accurate and satisfying

diagnoses. Upon the tentative diagnoses set down at the time, we make the following classifications: Twenty-seven (27) *psychoses*, mostly of a mild and easily managed sort; thirteen (13) probable *epileptics*, and one hundred and six (106) *feeble-minded*. No proper care of any one of these classes of patients can be expected or is extended in county poor farms.

In one place two brothers and a sister, all above 40, have long been on the county. A brother of these died at the institution about a year before my visit.

In one of the best agricultural counties in the state the county poor farm shelters an old woman, her illegitimate daughter, and two illegitimate children (boys) of this daughter. These boys are both of school age. The mother has never allowed them out of her sight.

Another very good county has a 300-acre farm, valued by the court at \$50,000, set apart to care for the poor. There were six inmates. One is a white baby boy of about two years. Another is a colored man of 76 years, suffering from "rheumatism." The other four are evidently feeble-minded. The mother of the boy is unmarried. She recently ran away from her unweaned baby and hired herself out at one dollar a week to a farmer's wife. A young colored woman is deaf and had the benefit of four years at the state school for the deaf, but was untrainable. She has "fits." She has worked for 50 cents a week, but could not keep her place. Another is a colored man of about 60 years, blind and silly. The other is a young white man, about 27 and capable of no other work than keeping track of where the turkey hens make their nests. These six persons are housed in a two-room cabin, about 24 by 12 feet, and 40 yards to the rear of the farm house. The doors to the two rooms are side by side and are never locked.

Another poor farm had 14 inmates, eight of whom were feeble-minded. Of these latter two were girls between 18 and 25. Both are syphilitic and epileptic. Their father came with them in the same condition. He staid during the winter, but with spring he had fared forth to further impair society.

3. According to reports made to the commission by the superintendents of the three hospitals for the insane there are housed as patients in their institutions, 171 feeble-minded persons, and 381 epileptics.



4. Careful examinational surveys were made for feeble-minded at the state schools for the blind and the deaf, Prof. Rudolph Pintner assisting in the latter. *Eight* (8) *blind* pupils and *twenty-four* (24) *deaf* were found, who, upon a most conservative estimate of future mental and social potentialities cannot be expected to develop sufficient common sense to manage their affairs with prudence and propriety. These all are bound to the same kind of career as the colored woman described above as found in a county poor farm. Money is wasted in so far as it is being spent to give these thirty-two (32) *defective children* a literary education. They cannot get such an education, and if they could get it, they could not use it.

5. A partial examinational survey was made of the resident population of the home and school of the Kentucky Children's Home Society. It was partial because two diseases were epidemic among the children at the time. Less than half of the children were seen on this account. Fifty-nine were given mental examinations and rated upon educational and social histories. Thirty-one (31) of these, more than 20 per cent of the whole population, are so defective in ability to adjust themselves to social situations that it is quite unreasonable to expect them to make their own way in the uncontrolled competition of our complex social conditions. This society, as an agent for the placing in homes of normal homeless children, should be relieved of the care of defective children.

6. With the help of Dr. Herman H. Young, of Youngstown, Ohio, detailed mental and social examinations were made of the inmates of the Kentucky houses of reform. As a result of our joint work in this field, and, we feel upon a very conservative basis, one hundred and ten (110) of the four hundred and sixty-three (463) boys and girls then resident as delinquents, are to be rated as so defective in intelligence equipment as to make it unreasonable to expect them to be reformed in the usual sense, or to be trained for self-directive citizenship.

7. The writer himself made a similar detailed survey of the population of the Louisville Industrial School. Of the four hundred and eighteen (418) boys and girls then resident, some as dependent and some as delinquent, thirty-nine (39) were found so defective in capacity to adjust to social situations that I classed

them as mental defectives who should at once be recognized as such and placed in training appropriate to such minds and held in custody so long as they fail to develop capacity for social living.

8. With Dr. Young a partial mental and social survey was made at the Frankfort Reformatory. The contract labor system at this institution made impossible any more exhaustive work. In the short time we did work there, we located thirty-four (34) *feeble-minded* and twelve (12) *psychotic* cases, amongst a total of one hundred and twenty-four (124) examined. This was about 9 per cent of the total population, and naturally the poorest part mentally. On visiting the Eddyville Penitentiary, I found they had an idle gang of 30 men—men out of whom no useful activity could be obtained.

9. The Kentucky Institution for Feeble-Minded Children cares for about 360 children. It is run, for the most part, as a school, and retains only a few beyond the ages specified in the law, and this in contravention of the letter of the law. At the time of the survey there was no training of the children. They were simply being kept as cheaply as possible. The new superintendent had found the institution several thousand dollars beyond its appropriation and had eliminated all school and training work as a means of making up the deficiency.

#### NUMBER OF MENTALLY DEFECTIVE PERSONS CARED FOR AT STATE EXPENSE.

Putting together the results of these institution and locality surveys, we find there are *more than 3000 feeble-minded persons now supported by the state*, either so-called "pauper idiots," or in correctional or custodial institutions of the state.

This leaves out of account the more than 300 defectives who wander into and out of county poor farms at will and bring forth of their kind more freely because of the county aid. These constantly increase the state expense for this class. No county institution should be allowed to care for a feeble-minded person who is a menace from the procreative point of view. It takes no account of the defective children in the public schools nor of those in the Louisville Industrial School. Of these there are several hundred.

The present annual expense to the state for the maintenance of delinquent and dependent mental defectives is considerably more

than three hundred thousand (\$300,000) dollars. And not one cent of this sum is being expended for the kind of training or the kind of guardianship which are demanded for the proper management of such persons. Nothing is being done to train them for such productive activity as they are capable of, and hence to make them happier. Nothing is being done to prevent the ever-increasing burden of their feeble-minded progeny. Much of the present expenditure directly favors the increase of this progeny and hence of state expense.

#### PLAN FOR EARLY TRAINING AND CUSTODY.

The state needs three large farms with buildings of the cottage type not more than two stories in height. These buildings should be suitable for colonies of 1000 at each colony. They should provide facilities for training schools and research laboratories. They should be constructed largely by the labor of inmates themselves, of brick or cement block which they could make on the premises. By having such a number of colonies in the state every feeble-minded child would be near enough to his home to make it reasonably easy for those interested in his progress to make him frequent visits. This contributes to the facility of commitment. The colony would at once become his home. He would rather be there than any other place, because he is happy there. The cottage plan facilitates the proper classification by sex, age, color and degree of mentality. It would allow also of the reception and management in the same institution of epileptics.

Each institution should be in charge of a medical man familiar with the problems of training and management of the mentally defective. Constant study of the social wastage from this source should be directed both to the benefit of the individual and of society.

The state should foster in schools and children's courts means for the early diagnosis of mental defect. Special schools should be provided for backward and defective children who cannot be placed in the colonies.

With the increase of diagnostic facilities in schools and courts, it will be possible to have a state register of mental defectives. This is a condition very desirable both for those within and those outside of training schools and colonies. With such a register in

formation it will be possible to develop a supervision, on the part of the state, of the defectives in private homes as well as of those in state colonies.

In order to secure the proper custody and management of defectives, legal provision must be made for diagnosis and commitment as well as for their parole and discharge. Courts should be afforded the help of well-qualified physicians. Appeal to jury trial must be preserved as a right guaranteed by the state constitution. It should be recognized, however, that such cases are primarily cases for mental and social diagnosis rather than for trial. Physicians are best qualified for this work. And once such diagnosis is made the judge and the doctor are best able to decide what treatment is most likely to bring the greatest benefit to the individual and to the community.

The "pauper idiot act" is an anachronism. It is of no service in the proper management of the feeble-minded, but only serves to increase the burden of taxpayers on this account from one generation to another. Its operation should be stopped as rapidly as proper provision can be made for its present beneficiaries.

#### LEGISLATION IN 1918.

As the result of statutory provisions made by the General Assembly in 1918, the institution at Frankfort for the feeble-minded is known now as "The Training School for the Feeble-minded." It is a part of a larger institution known as the "State Institution for the Feeble-Minded." The other part of this institution is to be a farm of not less than 500 acres to be located in the same or an adjoining county, and to be known as "The Farm Colony for the Feeble-Minded."

The sum of \$50,000 was appropriated for the start of this new institution, and in addition certain other revenues which can be saved from the present administration of the "pauper idiot act," by the admission of beneficiaries of this act into the state institution, are to accrue directly to the institution. Further the regular per capita allowance for institution inmates is to be allowed for the maintenance of each person admitted to the institution. The savings therefore from the administration of the pauper idiot act go directly to new equipment.

The institution is to be placed under the supervision of a competent medical man. His first assistant is to be a competent psychologist and physician.

No certificate for pension may now be granted to a pauper feeble-minded person for a period beyond January 1, 1921. This means the operation of the pauper idiot act ceases January 1, 1921.

Provision is made for the filing of a petition by any reputable resident of the county, with the clerk of a circuit court, setting forth the names and residences of certain kindred and friends of the one complained against as defective or insane.

Notification of these persons is provided for.

When such petition has been properly filed in writing, the court is directed to appoint two physicians who are familiar with mental defects and with mental diseases to examine the person in question and make and file with the court a certificate of their findings in the case.

Provision is made for the licensing and supervision of private institutions for the care of feeble-minded, epileptic and insane persons, by the Board of Control of Charitable Institutions.

Provision is made for the discharge of inmates from state and private institutions.

**NOTE.**—Further details of the results of the survey and also the "Recommendations of the National Committee for Mental Hygiene for the State Care of the Feeble-minded in Kentucky" may be found in the "Report of the Commission on Provision for the Feeble-Minded in Kentucky."



## THE ORGANIZATION OF THE STATE HOSPITAL SERVICE IN ILLINOIS.

By H. DOUGLAS SINGER, M. D.,  
*State Alienist, Department of Public Welfare.*

The increasing interest of the general public in efficiency of state government has led to closer attention to the organization of the Department of the State devoted to the care of handicapped individuals which represents one of the largest items in a state budget. The subject is relatively simple where there are but one or two institutions to be considered, but becomes increasingly complex as the number rises. Each institution is a unit which, because of varying conditions in different localities, must have considerable autonomy and yet, for efficient administration, it is essential that there be uniformity of general policy with proper provision for real responsibility.

Prior to 1909, Illinois, like most other states, operated each of its institutions as an independent unit under the direction of a local board of trustees. A State Board of Charities, advisory only in its functions, served to establish some small measure of coordination. The great defect in this system was the fact that each unit worked for its own interests alone and could thus bring about considerable inequality in the distribution of funds and other means for operation. The superintendent again was responsible only to the board of trustees who were unpaid and, acting as a board, could not very well be called to account.

The interference by politicians which obtained during this kind of management in many institutions cannot be attributed to the system itself, but the fact that such domination with all its baleful consequences could continue unchecked and largely unknown to the public must be considered a defect in the method.

The first big change in system was an effort to eliminate this political control by means of a Civil Service Act which became operative in 1905. This, at first, was applied only to the state hospitals, but has since been extended to the penal and correctional

institutions, although in all instances the managing officer is still excluded.

In 1905, also, the State Charities Commission became much more active by reason of the character of its personnel and this body did much to improve conditions generally and to lay the foundation for the next step which was taken in 1909 when the various boards of trustees of the state hospitals, the colony for the feeble-minded and the charitable institutions were abolished and replaced by the State Board of Administration.

This body consisted of five members appointed by the governor with the consent and advice of the Senate. It was provided that one member of the board should be a physician experienced in mental diseases and that at least two members should be of the minority political party. In other words it was a bipartisan board with the control in the hands of the majority party. The provision for the bipartisan character of this board unquestionably tended to bring with it a recognition of politics as a factor in determining its personnel. An attempt was made to guard against the domination of the board by politics by arranging that the term of office should be six years, thus exceeding that of the governor by two years. The terms were so arranged that not more than two would expire in one year. In practice this provision was, however, nullified by the ability of the governor to secure the resignation of all members at his request.

The board acted as a whole, each member casting his vote upon any question which might come up even though the functions of the individual members were vaguely defined by their designation as president (elected by the board), secretary, fiscal supervisor and alienist. The fifth member had no title. The defect in this arrangement is obvious. The alienist, for example, although selected because of professional experience, had theoretically no more voice in determining the medical policies of the hospital than had the secretary or fiscal supervisor. Hence he could not in any sense be held responsible.

Through this administrative body it was possible to secure far greater uniformity of methods and budget organization within the hospitals. All purchases for all institutions were also made by it upon requisition of the managing officers thus rendering it possible to buy more economically. Although not inherent in the system,



the practical result of its methods of operation was a gradual centralization of authority in the board, even in regard to details, with corresponding loss on the part of the individual superintendent. This is a danger that must always be guarded against by any central body for, under such conditions, the superintendent can no longer be held responsible.

To assist in the direction of the professional work of the hospitals, a state psychopathic institute, originated by the State Board of Charities in 1908, was officially established in 1909 by the act creating the Board of Administration. The alienist was designated by the board as the director in chief of the institute. Founded with the objects of giving psychiatric instruction to medical officers and conducting research into the problems of insanity it had, however, no authority in the hospitals except through the Board of Administration.

In 1917, as the result of the personal efforts of our present governor, Frank O. Lowden, there was passed a code of civil government which has in effect resulted in the abolition of approximately one hundred boards and commissions and their replacement by nine state departments. The prime objects of this development were the removal of scattered, and often duplicated, authority and the establishment of really responsible management in all fields of state activity. Among others the Board of Administration was abolished and its functions centered in the Department of Public Welfare. At the same time the boards of trustees of the two penitentiaries and of the reformatory, together with certain other boards and commissions, were abolished and their activities brought under the same department.

The civil code provides that each of the nine departments (which are known as finance, agriculture, labor, mines and minerals, public works and buildings, public welfare, public health, trade and commerce and registration and education) shall be under the command of a director responsible for the work of that department. It also creates a number of divisions within the departments each with an officer at its head. The directors and their staffs are appointed by the governor by and with the advice and consent of the Senate. All subordinate positions, with the exception of the managing officers of the various institutions who are appointed by the director, are selected through the Civil Service Commission.

The system of organization within each department is essentially similar and we need describe only that of the Department of Public Welfare in which mainly we are here interested. The staff consists of seven members, four of whom are administrative and three functional. They are: An assistant director, a functional officer who acts as secretary, keeps the records and has charge of the seal; a fiscal supervisor who superintends the business transactions of the whole department; a superintendent of charities who is responsible for the operation of the hospitals for the insane, the school for feeble-minded, the epileptic colony, the schools for delinquent boys and girls and the charitable institutions; a superintendent of prisons, responsible for the administration of the penitentiaries and reformatory; a criminologist who acts also as the director of the Juvenile Psychopathic Institute and is responsible for the professional work in the penal and correctional institutions and the direction of the machinery for the study and prevention of delinquency and the after-care of delinquents; an alienist who directs the teaching and research work of the Psychopathic Institute, supervises the medical and professional work of the state hospitals, school for the feeble-minded, epileptic colony and the charitable institutions.

Besides these seven officers there is also within the department a Board of Public Welfare Commissioners, five in number, who serve without pay, but are provided with an executive secretary. The functions of this board, which replaces the State Commission of Charities, are advisory but they are specifically required to investigate the condition of the various institutions under the Department of Public Welfare, their equipment and management and to collect and publish statistics relating to insanity and crime.

Each officer is directly responsible to the director for the work of his division. The functions of each are now reaching a clear definition. The organization is therefore essentially different from that of the Board of Administration in which each member had equal authority in all matters. The scheme also provides for a very valuable distinction between administrative and professional work. These two functions are so different in character that it is very rare to find any individual capable of performing both and there has been a very general tendency to subordinate medical to administrative qualification, which is, in my opinion, largely

responsible for the slow development of our state hospitals. They are almost universally well managed in the way of general upkeep, but there is only too often a decided poverty in professional progress.

Under the Illinois system the managing officer of a state hospital is responsible for the operation of the institution to the superintendent of charities, but is subject to the direction of the alienist in regard to matters involving the professional care and treatment of patients. Means for cooperation between the various divisions is provided by holding staff meetings over which the director presides.

The administrative machinery is perhaps a little complex, but in practice works very smoothly. The purchase of supplies is made by the superintendent of a division of purchases and supplies in the Department of Public Works and Buildings and not by the Department of Public Welfare. Requisitions from the managing officers pass through the hands of the fiscal supervisor and are then sent to the purchasing division which buys everything used by the state government. The forms to be used for bookkeeping, vouchering, etc., the preparation of the budget and the financial supervision generally are vested in the Department of Finance. The erection of buildings, supervision of architecture and engineering work for the whole state including the institutions under the Department of Public Welfare are upon requisition conducted by the Department of Public Works and Buildings.

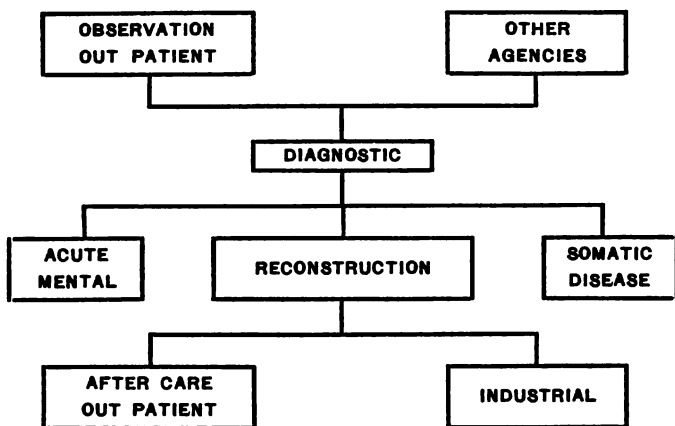
To ensure cooperation in these interdepartmental activities meetings of the directors are held at frequent intervals at which general policies are discussed and decisions reached. This body thus acts as a cabinet to the governor and serves to preserve a proper balance in the work of the state.

I have already called attention to the provision for separate control of the administrative and professional work of the institutions. This division of duties brings with it the possibility of establishing a clear-cut professional organization of the state hospital which should be the central feature around which the administration is built instead of dividing the institution for convenience in administration as is usually done. As yet the department is too young to have succeeded in finally defining such a scheme, but a tentative arrangement has been adopted which I have described

in some detail in a paper now in the press. This I may here briefly outline.

The scheme is shown in graphic form on the accompanying chart. The two groups in the top line represent the agencies through which a patient enters the institution that to the left being part of the hospital organization chart. The chief feature of the plan consists in the establishment of a "reconstruction" division through which all patients must pass before being either released,

#### PLAN OF STATE HOSPITAL ORGANIZATION



with or without supervision, or being placed in the custodial or, as here called, industrial division. This reconstruction division carries out work which should be considered as the principal function of a state hospital. Its aim is the rehabilitation of the individual to the highest degree possible, whether he must remain permanently within the institution, in which case he is trained for taking part in its industrial work, or is to be permitted to resume more or less of the responsibilities of citizenship. In this latter case the effort is made to fit him better for life in the world by giving instruction in occupation and habits of adjustment.

The hospital divisions, one for acute mental disorder and the other for somatic disease, take their place as adjuncts for temporary residence in which are provided special means for treatment designed to promote a return to sufficient health to permit of reconstructive work.

Special attention may be directed also to the provision for special observation wards and outpatient departments which, according to circumstances, may or may not be located within the confines of the hospital. In any event they form a most important part of the organization both for prevention and after care and will also include the means for obtaining information for use in diagnosis. The diagnostic division, which will include the laboratories, corresponds with what is usually known as the reception service, but is given this title in order to emphasize and clearly define its functions.

The division labelled "industrial" corresponds with what is more commonly designated as the custodial service and necessarily contains the large bulk of the inmates of the institution. The title here used is intended to convey what I believe should be its real function. Idleness should not be permitted and the fullest use possible should be made of the capacity for employment of those who must remain segregated from the world not only for economy, but also for the benefit of the patients themselves. As already indicated, special training with this in view will be given in the reconstruction division.

Such, in brief, is the plan upon which the Illinois state hospitals are being organized, but before concluding let me call your attention to another feature in the provisions of the civil code which we regard as one of the most important. This concerns the inclusion of the penal and correctional, in the same department with the insane and charitable, institutions. That crime and delinquency are disorders of behavior requiring similar methods of study and diagnosis to those of insanity, feeble-mindedness and dependency is gradually being recognized. Under the Illinois system there becomes possible a very close cooperation between the two groups with interchange of means for study and treatment. The medical staffs have been amalgamated in the sense that physicians can be transferred from one group to the other, thus providing for a broader training of medical officers and the introduction of psychiatric methods into the penal and correctional institutions. The general plan for the professional organization of the penitentiaries is being made to follow very closely the lines laid down above for the hospital.

The machinery for research and preventive and after-care work will also, to a large extent, be fused so as to avoid unnecessary

duplication and permit of the greatest economy. This work is as yet in its infancy in this state, but a beginning has been made by the establishment, in temporary quarters, of the Juvenile Psychopathic Institute in Chicago which is, at present, serving not only in the study of delinquency and juvenile behavioristic problems, but also in the after-care of cases from those state hospitals which receive from the Chicago district. This it is planned to greatly enlarge and to incorporate with the Psychopathic Institute in permanent quarters. This institute thus formed will act as a research and teaching center which will in all probability have close relations with the medical college of the State University.

The outline here given is necessarily somewhat sketchy, but will afford a general idea of the plan of operation. Its principal advantages are: (1) The establishment of direct responsibility in all fields; (2) the elimination of much unnecessary reduplication of machinery, and (3) the clear recognition of the distinction between professional and administrative functions.

#### DISCUSSION.

DR. BRUSH.—Mr. President, I did not appear to read my paper for one of the best reasons: because the virgin page is still unmarred with ink. I felt, however, when I saw the program that Dr. Pilgrim and Dr. Singer would say so much better things than I hoped to say, that not only would I be excused for not saying it, but I would be justified in not attempting to say it. I have heard with very great interest the report of the Hospital Development Commission from New York State; I have heard it with greater interest because New York is my native state and because I served for seven years on the staff of the state hospital at Utica. During those seven years I appeared before five committees of the Legislature who were investigating either charities of the state, reformatory institutions of the state, state hospitals for the insane or some special institution, and when I appeared before those committees I recognized that I was appearing before a prejudiced body of men who felt that nothing was too bad to say about the institutions for the insane. I am very glad, therefore, that the time has come when a committee made up largely as this committee is of legislators, guided to be sure by the judgment of wise physicians, has made a report in which it gives full, though tardy, credit to the work of the physicians of the state hospitals.

Dr. Singer's elaborate program which he has described is an ideal one, if the men who have power also feel responsibility and the men who have responsibility also feel that they have some power. If the heads of these

various departments, which Dr. Singer has elaborately described to us, are going to say to the doctor in the hospital, you must walk this line, and to the assistant physician in that hospital, you must do so and so, they take from him his power of individual judgment. Years ago Dr. Gray at Utica, who was given to aphorisms, said that power without responsibility was dangerous, and that responsibility without power was weakness. The hospital is a medical institution and it is not anything else; it is an institution for the care of the sick and disabled, the cripple and the insane, and as a medical institution the man who should have the ultimate say as to the conduct of that institution should be a medical man and he should have the feeling that when he says a thing he should be given a fair chance to try his method, and that no board of management is going to step up and remove him from office and put another man in his place without giving him any opportunity to show what was in him. In most instances where such removals are made, men are put in positions who have had no previous experience which would warrant any expectation from anybody of their doing any good medical work.

Is it not better to have, as in New York, Massachusetts and other states, a board of managers who are in close contact with the superintendent of the hospital, who holds him responsible for the medical care of the patient, who, so far as I know from any experience I have ever had, never interferes with the appointment of a single person from scullery maid up to the steward? Then and then only is the medical superintendent master of the situation. I believe the most is accomplished when each institution is managed by its board of managers and the boards meet in conference as they do in New York State; they do just as we are doing here to-day and they improve along the whole line as they get ideas from one another. I do not believe that the members of this association believe that they alone can manage and conduct hospitals. I believe with the profession all over the United States, that the conduct of a hospital is a medical question; that that medical question takes in the occupation of patients; that it takes in the proper hygiene of the hospital as well as the diagnosis; that it takes in the food supply just as well as the industrial occupation, and that any superintendent who is worth his salt can do good medical work by surrounding himself with good subordinates, for whose appointment he is responsible and to whom they feel responsible.





## THE REHABILITATION IN THE COMMUNITY OF PATIENTS PAROLED FROM INSTITUTIONS FOR THE INSANE.

By SAMUEL N. CLARK, M. D., CHICAGO, ILL.

The subject broached by the title of this paper is too vast to be discussed here except in very general terms, but a broad survey may serve to open the topic for further and more specific investigation.

The needs for the return of all recovered patients to life outside the institution are too well known to recount and yet a special word here may not be amiss. The community and the individual are best served by the fullest expression of activity of which the individual is capable. It must be remembered, however, that the ability of the individual to withstand stress is not always easy to estimate. Adequate reaction to a difficult situation for a few days, weeks or months may be followed by excessive oscillation of mood or by the substitution of a false trend of ideas or fantasies for stern reality. Once such disorientation is accomplished the services of the individual are lost to the community probably for considerable time. Obviously it would be better were such case required to meet only situations to which he is able to react repeatedly without mental capitulation. It is most important that this idea be comprehended and one must remember that it is diametrically opposed to the belief rather widely held that everything is possible if only the individual is willing to make the necessary effort.

The fact that a mental disorder has occurred strongly suggests that thereafter there must be a compromise between the efforts of the patient and those of the ordinary individual. The question of degree of compromise necessary in a given case is difficult, but upon it depends the future welfare of the patient and an attempt to solve it must precede the restoration of the patient to life outside the institution.

The ability to answer the question in the preceding paragraph is dependent upon knowledge of the factors which have in the past caused more or less marked mental upset. These are not only the unusual stresses to which the patient has been subject; acute or

constitutional illness, psychic trauma, etc., but also and even of more importance those habitual tendencies on the part of the patient to react to certain situations in a harmful manner.

The way in which ordinary problems are met is portrayed in the usual behavior of the individual. At times the reaction to certain everyday situations is of a sort which fails to pass the censorship of the social code. In other cases no unusual manifestations are noted until an unusual situation arises, be it the death of a friend, financial upheaval or actual change in structure of the brain. Even in such case it is not the situation which constitutes the immediate need for social supervision, but the behavior under the existing conditions.

In speaking of etiological factors of mental disorders the writer refers to the conditions which cause any of the disturbances of behavior commonly spoken of as insanity. It is easy to refer to etiological factors in general terms but often difficult to say specifically what things should be avoided. Of course, carefully taken anamneses will aid greatly in pointing out probable pitfalls, but occasionally these are difficult to obtain. In such case one must look elsewhere for guidance. The fact that there is doubt as to the sort of problems or situations which may be considered probable factors does not excuse one from making an attempt to outline the activities of a recovered patient. If a patient is placed under the jurisdiction of a department there is no choice but to use the data available in an effort to safeguard him even if interpretation of the data is somewhat open to question. The experience one has had with other cases will be of aid. There is food for thought in the frequency with which cases improved following acute episodes of the dementia præcox type of disorder, show an apparent narrowing of interests and a disinclination for any but the more automatic sorts of industry. It may be presumed that this fact has a general application to all disorders based upon a difficulty in adjustment and that it points to the need of caution in returning individuals no longer manifesting acute evidences of mental disorder to active life. If one may surmise that the apparent inclinations of these patients are actually preservative, one may say that the characteristics which are conspicuously absent in the improved dementia præcox case, are ones which the patient cannot assume without risk. Among these characteristics are the assumption of

responsibility; a tendency to compete with others to the degree that ordinary individuals compete; and a willingness to submit new ideas, if indeed any are conceived, to public opinion. Obviously no attempt can be made here to define a "complex situation," but perhaps one is justified in saying that the characteristics mentioned in the preceding sentence are some of the earmarks and they may be in evidence not only in industrial activities but also in the family and social life of an individual.

If it may be assumed that the recovered patient should refrain from undertaking great responsibilities and from attempting to compete with the most active the question is presented: What then may he do? Idleness is certainly not advisable, as it would favor reactions not censored by reality. From consideration of the inclinations of the dementia præcox case one learns not only to refrain from placing him in the most complex situations but also that if not roused and stimulated to some extent, progressive disinterest in the environment is very apt to result.

It would be useless to try to specify the type of work all cases should do, hours of employment, home conditions, recreation, etc., which are most favorable for all paroled cases. Each case must be treated as a problem distinct from all others, but the general principles outlined should be kept in mind. The criterion to be used in the estimation of the suitability of a given situation is whether the accomplishments of the individual keep pace with his aims. In so far as can be done by the prescription of certain occupation and recreation and by regulation of stimuli in the matter of home conditions one should try to make the aims of the patient as broad as seems consistent with his continued welfare. This done, he should be watched closely to see if the aims are realized, and if not steps should be taken to simplify them. By "aim" is meant here not simply desire, but the actual assumption of responsibility for certain definite results. A homely illustration may make this somewhat abstract thought clear. If a man desires a fortune but feels no obligation in obtaining it, failure to gratify the desire is not apt to result in mental upset. If he feels obliged to gain a fortune and succeeds, the aim leads to no difficulties; but if instead of success he meets with failure the inability to react adequately to the aim necessitates a readjustment. In one given to subterfuge or in whom unusual oscillations of mood are apt to occur in ordinary

situations such readjustments as those just mentioned are likely to lead to mental disorder. They are the especial stresses of life.

The rehabilitation of patients who have passed through the more acute manifestations of mental disorder must begin in the hospital. From the time the case is received at the institution efforts should be made to obtain information in regard to the make-up of the individual, especially as to the character of the situations faced which led to disturbances of behavior. After the acute disturbance has subsided the work of re-education must be instituted. There is no justification for delay in rehabilitation until the patient is paroled from the institution. It is the duty of the hospital to fit the patient for life outside the institution so far as this is possible by advice, instruction and habit formation. When it has been decided that a patient may be released from the hospital there should be available some organization which properly may be termed an out-patient department to carry out supervision begun in the hospital. This department may quite well be a part of the state hospital, but its scope will differ widely in certain respects from the ordinary work of the institution. It may be said that while the patient himself constitutes the field of endeavor of the hospital, it is the environment of the patient in the world at large which the out-patient department attempts to control and shape. Instead of being the custodian the out-patient department becomes the mentor; and while compromise with the activities of the ordinary citizen still must be considered, the broadened outlook of the patient with consequent multiplications of the reactions changes greatly the aspect of the problem of his welfare. In place of stage-settings entirely subject to the desire of the hospital physician, the out-patient department must make use of the activities and interests of the world at large. The difficulty is not that the activities are too few, but that the capabilities of the patient most frequently precludes anything but the cautious assumption of the ordinary responsibilities of citizenship; and lest the patient attempt too much, the scope of the out-patient department must be such as makes it possible to reach out and keep pace with the patient's activities, even to anticipate them, to mold and to limit the situation to which he must react.

The number of workers which is necessary to carry out the work outlined depends altogether upon the number of paroled

patients in a given district and the size of the area to be covered by the visitors. An organization may be sketched, however, which will cover the necessary activities. There should be included a medical director, an examining division and a social service department, and if desired an occupation bureau may be added as a special branch of the last named.

The medical director shall coordinate and direct the work of the department. Under his guidance each subdivision shall carry on its particular task.

The workers in the examining division must be trained in medicine, especially in psychiatry. It is the business of this department to consult with the paroled patients when the latter make their regular visits to the department. The physician should make the necessary progress notes, advise the patient in regard to his activities and watch closely for evidences that he is finding difficulty in adjusting to the situation. Such evidences might be irritability, abstraction, depression, insomnia, the complaint of pain or distress not founded on organic change, etc. If unusual problems in the life of the patient arise special attention should be given him in an attempt to aid him to weather the storm. There is need for care that acute somatic illness shall not remain undetected and that the progress of chronic disorders, neurological or otherwise, be gauged.

The work of the social service department should include investigation of the home before the patient is paroled, to judge of its fitness as a habitation and of the probabilities of the patient being supplied with ordinary needs of life. The attitude of the others in the home should be learned, and where indicated an attempt should be made to educate the members of the family in regard to an understanding of the disorder through which the patient has passed and of the factors which might cause future attacks. Occasionally it may seem unwise to return the patient to his former home. The social life, recreations and avocations should be scrutinized; in a word, all the interests should be considered with the aim of directing so far as is possible the activities of the patient. This will necessitate talks with the patient and occasional consultation with relatives or friends.

If desired, a special bureau can be formed to obtain employment for the patients and whether this is done or not the occupations

followed need consideration. The experience and preference of the patient must be weighed in the choice of employment, but at times new fields will seem advisable and the preference of the patient may seem unwise. Here the problem is difficult and must be left to the discretion of the department.

Unfortunately the wages are frequently a necessary item and the actual needs for financial aid makes unavoidable occupation which is undesirable. Even in such case there is room for endeavor on the part of the out-patient department. In certain instances it may be advisable to take the employer into confidence and enlist his aid. If the latter knew the condition of the patient he would at least, in many cases, be more willing to transfer the patient to more desirable work when opportunity arose.

Of course the problem of prevention of future attacks is very closely allied to the one of rehabilitation, although it is not embraced by the title of this paper. Perhaps the statement may be made here that the data in regard to onset of past mental disorders and the out-patient department as an organization would be applicable to the problem of prevention as well as to rehabilitation.

Finally there is the question of control of the patient. The solution of this problem will be aided by an understanding between the staff members of the state hospital and the patient, that the parole of the latter will be granted with the understanding that he will visit the out-patient department and abide by the advice tendered there in regard to occupation, etc. This understanding will give the out-patient department a lever with which to gain access into the life of the patient. Such hold is a very poor substitute for real understanding which should be established as rapidly as may be. It is only when a sympathetic contact is accomplished that the stage is reached where advice may be given and accepted which actually results in alteration of viewpoint on the part of the patient. And this is the highest goal of therapy of most of our recoverable insane cases: to aid the patient in arriving at an understanding of his limitations so that he will attempt only the activities to which he may react safely and continuously.

# A CLINICAL SUMMARY OF 106 CASES OF MENTAL DISORDER OF UNKNOWN ETIOLOGY ARISING IN THE FIFTH AND SIXTH DECADES.

By E. T. GIBSON, M. D., MIDDLETOWN, CONN.

## CONTENTS

	PAGE
Introduction .....	223
Nature of material .....	226
Choice of material .....	227
Diagnostic summary of cases .....	227
Special groups .....	228
Manic-depressive psychosis .....	228
Dementia præcox .....	233
Unclassified .....	234
Clinical summary .....	241
Age and sex .....	241
Heredity .....	241
Alcoholism .....	241
Syphilis .....	241
Physical diseases and defects .....	241
Delusions, hallucinations, affect .....	242
Katatonic symptoms .....	244
Prognosis .....	246
Summary .....	248
Conclusions .....	251

## INTRODUCTION.

A review of a large number of cases which have been studied extensively rather than intensively is not likely to be of much value unless there is something novel in the kind of material or in the point of view.

In the present paper the data of the separate cases are banal. The cases themselves include those psychoses of the involutional years which have evaded definition under all the schemata of the descriptive psychiatrists. One claim for novelty is that the cases are drawn from a psychopathic clinic, and, as will be pointed out later, more nearly approximate a complete collection of mental disorders as they actually occur than would a group of necessarily com-mitable cases. The other claim for more or less novelty lies in

the point of view; namely, the age at onset, using the decade as unit.

The advantages of such an approach have been pointed out before, notably by Southard and Bond (*AMERICAN JOURNAL OF INSANITY*, 1914, LXX, 779, 828). In a group which includes the involuntional psychoses, the standpoint of age is obviously the logical one. To attack such a group with preconceptions of disease-processes or symptom-pictures is really to beg the question.

One is struck by the number of symptoms, syndromes and even so-called diseases which have been described as characteristic of this time of life. It would probably be admitted that agitated, depressions, certain metaphysical delusions, "Cotard's syndrome," "late katatonias," etc., do occur with greatest frequency in the 5th and 6th decades, but I have been unable to find any review of the mental disorders of this period which would permit one to form any idea of the frequency and proportional value of these features.

If it is granted that something may be gained by a review of psychoses of the involuntional period, the need at once arises of having as a basis for comparison observations in other decades. As a preliminary to the present survey, a study of 6000 consecutive admissions to the Boston Psychopathic Hospital has been made. (In course of publication in the *Bulletin of the Massachusetts Commission on Mental Disease*.)

The following paragraphs are quoted from the summary of that paper:

The cases upon which the study is based include, in addition to groups found in state hospitals of the usual type, a considerable proportion which represents mental disorder but not "insanity" in the legal sense. These are the groups which are responsive to the special appeal of a psychopathic hospital. The statistics, therefore, as a whole, present a more accurate picture of the entire incidence of mental disorder in the community than reports from state hospitals.

The use of the decennial unit avoids to a large extent errors in statement of ages, and allows any psychotic forms characteristic of the principal epochs of life to appear more clearly. According to Table IV, the predominant diagnoses in the various ten-year periods are as follows:

1st decade: Congenital syphilis.

2d and 3d decade: Dementia præcox with manic depressive types increasing in prominence.

4th decade: Dementia præcox still most prominent, with paresis and alcoholic psychoses increasing in males, and manic depressive psychoses in females.



5th and 6th decade: For men, the decade is characterized by the occurrence of several forms in about equal number, namely: Paresis, manic depressive psychoses, dementia præcox, delirium tremens, alcoholic hallucinosis, arteriosclerotic psychosis, etc. For women, there is a tendency to ill-defined forms which are not easily diagnosed. Of these the groups of presenile, involutional, and unclassified psychoses make up in the two decades respectively 22.1 per cent and 33.8 per cent.

7th decade and following: Senile and arteriosclerotic psychoses are the prevalent ones, comprising about half in the 7th decade and a much larger proportion subsequently.

The large proportion of cases in the 5th and 6th decades which are left "unclassified" or placed in the indefinite and unsatisfactory groups of presenile and involutional psychoses indicates the need for further work upon psychoses occurring between the fortieth and sixtieth years.

In the manic-depressive psychoses the maximum for males falls for depressions in the 6th decade, for manias in the 3d. For females the maximum for both types fall in the 4th decade. Disregarding sex, manias predominate before and depressions after the fortieth year.

Dementia præcox appears equally in males and females. During the twenties males were in considerable excess, while during the thirties females were in excess; fifty-seven and seven-tenths per cent of all the females and 39.3 per cent of all the males were past 30 when admitted.

The specific diagnosis "not insane" was made in 9.37 per cent of all admissions. The groups which may be considered made up of cases not committable as "insane" (though certain individuals in them may be committable) comprise together 1406 cases, or 23.43 per cent of all admissions. This group probably represents roughly an actual gain in psychiatric service to the community.

TABLE I.—SHOWING DIAGNOSTIC GROUPINGS OF 1567 CASES BETWEEN THE AGES OF 40 AND 59.

	Male.		Female.	
	No.	Per cent.	No.	Per cent.
Traumatic psychoses .....	9	1.0	1	0.1
Psychosis with cerebral arteriosclerosis and with organic brain disease.....	56	6.6	18	2.7
Infective exhaustive psychoses.....	13	1.5	11	1.6
Syphilitic psychoses .....	181	21.0	43	6.1
Alcoholic .....	253	29.6	82	11.5
Dementia præcox .....	113	13.1	180	25.4
Manic-depressive psychoses .....	107	12.4	131	18.5
Epilepsy .....	17	1.9	18	2.5
Senile dementia .....	7	0.8	12	1.7
Presenile and involutional psychoses.....	12	1.4	96	13.6
Unclassified depressions .....	14	1.6	17	2.4
Unclassified .....	78	9.1	98	13.9
	860	100.0	707	100.0

The above table (I) shows the diagnostic grouping (with many condensations) of that part of the 6000 cases which fell in the years from 40 to 59, inclusive. The last three ill-defined groups in the table make up 20 per cent of the cases in two decades, but only 10 per cent of the entire 6000 cases. In other words, we have a numerical expression of the uncertainty in diagnosis which the psychiatrist meets in cases in the involutional years.

#### NATURE OF MATERIAL.

The material available at the Psychopathic Hospital possesses some particular advantages for a study of this kind. Patients are committed by physicians, or are sent by the police, or are admitted at their own request. They are drawn from metropolitan Boston and represent fairly the incidence of mental disease (apart from delirium tremens and drug addicts) in a large cosmopolitan population. The admission rate of 2000 a year is very nearly the full capacity of the hospital, and as no admissible cases are turned away, this number is approximately the normal under the conditions mentioned, and is closely related to the actual occurrence of psychoses in the population. In the great majority of cases, the patients are under observation for a short period of the time when their mental disorders have reached a stage which renders their life in society impossible. Observation in the hospital is usually limited to this acute period, so that a full record of the mental disorders is not always obtainable. The residence of the patient in Boston, and the efficient Social Service Department allows rather better accounts of their past history than can be obtained by most hospitals for the insane. Subsequent histories of cases are usually readily obtainable in the proportion which are transferred to other state hospitals.

The data utilized included age, sex, social status, time in hospital, diagnosis (which in all cases was the collective opinion of the staff), duration of illness, Wassermann reaction, alcoholic history, a short description of the mental condition, condition on discharge, and destination on discharge. It has been possible to obtain also, in a large number a report as to mental condition from one to five years later, in those cases transferred to other state hospitals, or kept track of through the Social Service Department.

## CHOICE OF MATERIAL.

Two thousand cases admitted consecutively to the Psychopathic Hospital in Boston were reviewed with respect to the age at onset, and 345 were found to fall between the years of forty and fifty-nine. The following groups were excluded from this number on the ground that they had no epochal significance.

	Cases.	Per cent of all excluded.	Per cent of total cases.
1. Continuous or periodic disorder beginning before 40 .....	106	44.4	30.7
2. Diseases with known exogenous causes.....	48	20.1	13.9
3. Senile and organic cases (including arterio- sclerotic psychoses) .....	31	13.0	9.0
4. Unclassified cases beginning before 40, pa- tients with meager history or those not insane .....	54	22.5	15.4
	<hr/> 239	<hr/>	<hr/> 69.3

The remaining 106 cases, 30.7 per cent of those of the 5th and 6th decades, form the material of the present study.

## DIAGNOSTIC SUMMARY OF CASES.

According to final diagnosis at the hospital the 106 cases fall into 25 groups. These may be placed in larger classes as follows:

Manic-depressive psychosis .....	38
Dementia præcox, paraphrenia and paranoic condition.....	27
Unclassified, "no diagnosis" and indeterminate diagnosis....	28
Presenile, involutional and unclassified depression.....	13
	<hr/> 106

Thus 41 cases or about 38 per cent of the selected group are not definitely classified. Another characteristic of the 106 cases appears if we compare them according to the proportion of the sexes with the admissions during the 5th and 6th decades of the 6000 cases.

	Males.		Females.	
	No.	Per cent.	No.	Per cent.
Selected cases .....	30	28.3	76	71.7
Cases admitted in 5th and 6th decade, 6000				
P. H. cases.....	1010	54.9	831	45.1
Six thousand cases, all ages.....	3125	52.1	2875	47.9

In the selected "functional" group 71.7 per cent are females. Of all cases in a series of 6000 admitted between the ages of 40 and 59, 45.1 per cent are females. The latter proportion is very nearly the same as the percentage of females (47.9 per cent) in the entire series of 6000, disregarding age.

#### STUDY OF SPECIAL GROUPS.

About two-thirds of the 106 cases could be placed with more or less certainty under the captions of manic-depressive psychosis and dementia præcox. The remaining third did not readily admit of classification. The considerations upon which these distinctions were made are mentioned in connection with the discussion of the separate groups.

#### MANIC-DEPRESSIVE PSYCHOSIS.

Thirty-eight cases showed the usual features of manic-depressive psychosis, and were so called at the Psychopathic Hospital and subsequent hospitals if there were any. The maniacal cases will be treated separately. The depressed cases are subdivided along the lines of motility—that is (1) as retarded, (2) as agitated, (3) as both, and (4) as showing no particular motility disorder. This division is made largely for the purpose of bringing into view the agitated depressions which have been looked upon as peculiarly associated with the involutional years.

In all the manic-depressive cases, family history of mental disease is mentioned in only five cases (362, 1917, 966, 1901, 1863), the relatives being, respectively: sister; father; brother and sister; aunt and two uncles; daughter, mother and sister.

Mention is made of menopause in nine cases, as follows:

Two (1173, 1676). Ten years before onset.

One (1241). Five years before onset.

One (388). Three years before onset.

Five (1192, 1138, 178, 1777, 1768). Onset during menopause.

In seven cases there was evidence of physical disease:

One (553). Irregular pupils, palpable arteries (W. R. & S. F. Neg.).

Two (87, 1834). Scar of hysterectomy (1834, recent).

One (882). Vesico-vaginal fistula.

One (517). Carcinoma of penis.

*Manic Phase.*—There were eight cases in this class, five female and three male. Five had passed through previous attacks, but had none before 40. Subsequent history of six was obtained. Two were discharged recovered, two improved and two unimproved. Two were still in a state hospital four and five years later, one improved and one unimproved. These cases were all described as euphoric, hyperkinetic and distractible.

*Manic-Depressed with Retardation*—This group comprised 14 cases, six males and eight females. In four there had been previous attacks, and in one a subsequent attack is reported. There is no record of the later condition of eight. Three of these were discharged from the Psychopathic Hospital improved and two unimproved. Of the remaining six, one is reported through the out-patient department two years later to be "nervous and tearful." Two were discharged from other hospitals recovered, one improved, one died of lobar-pneumonia, and one was in the hospital four years later unimproved.

Five of the patients expressed no delusions. One (239) had a feeling that some indefinite calamity impended, and one (362) repeated monotonously, "What shall we do when cold weather comes." Three had somatic ideas: (1842) "intestines stopped up and everything moving about inside the body," (87) "feels bad all over," (1901) "an awful impression, a dead feeling about heart." There were persecutory delusions in three; in one, coupled with self-reproach. In one the dominant feeling was suspicion, and in the third there was a definite reaction of aversion to the men of the family. In two the dominant feeling was one of self-reproach, one (1241) had ill-treated her sister, and one (1777) felt she was pregnant by the son of a friend. Three threatened or attempted suicide. Hallucinations (flashes of light) were described in only one case aside from the general somatic feelings mentioned above.

*Manic-Depressive, Depression with Agitation*—This group consists of seven females and one male. None of the cases had had previous attacks, but three had recurrences. Three were improved and one was unimproved upon discharge from the Psychopathic Hospital. Of the five with after-history, two were still in hospital four years later and were reported improved, and one was recovering from a third attack. Two had been discharged, one after a year as improved and one after two years as unimproved.

Delusions were present in all. In one there was a feeling that "something dreadful would happen." The ideas were self-condemnatory in four (92, 154, 882, 1134). In one of these (882) there was a real basis in the odor from a vesico-vaginal fistula. In four the patient was the object of persecution. Hallucinations are described in two cases: "little voices inside" (882), and "people talking about her character" (1768). General somatic ideas were found in one case (1956) in which there was a complaint of many pains, for which no cause could be discovered.

*Manic-Depressive with Both Agitation and Retardation.*—In one case (1676), there was usually retardation passing over into agitation at times. This patient, a female aged 55, was suicidal and self-condemnatory. In a second case (350), a female aged 53, speech was retarded although the general behavior was agitated. This patient insisted that her "bowels would not move." She died of broncho-pneumonia while in the Psychopathic Hospital.

*Manic-Depressive without Conduct Disorder.*—There were six cases, three male and three female, in which motility was not a prominent feature. Two (722, 178) had passed through previous attacks, and of these one (178) had a subsequent attack. All the cases had well-marked delusions. Three had somatic delusions, "evil spirit in belly" (553), "face not right, frozen stiff, cannot get heat into body" (388). "Bowels tied up, pins and needles in flesh at night" (722). One of these cases (722) was complicated by alcoholism. The patient heard voices from his stomach, thought he had improper relation with men, and possibly had some degree of peripheral neuritis (pins and needles). The delusions of the other three cases were of the persecutory type, in one case (963) in the future tense. One female (178) heard people outside on street talking about her.

One patient (517) had carcinoma of the penis, of which he shortly died. One (178) recovered from this attack and also from a subsequent attack. A third (722) was discharged in seven months, "much improved." One (553) was in hospital three years later, unimproved; of the remaining two cases (963, 388) there is no later account.

*Discussion.*—The principal facts available about the manic-depressive cases are shown in Tables II and III. The outlook, it appears, is rather favorable, in that only five out of the 22 with

after-history were not improved or recovered. An important characteristic of the manic-depressive psychosis is repetition of attacks. Although the longest after-history is less than five years, there was account of more than one attack in 16 out of the 38 cases. The proportion would doubtless be greater if the cases were followed longer. Recurrence is of especial interest in the agitated depressions, because of the association between this type of reaction and a poor prognosis suggested in Kraepelin's treatment of the subject in his latest edition. Although he abolishes the picture of involuntional melancholia in favor of a mixed phase of the manic-depressive psychoses, it is noticeable that the four or five "presenile" groups tentatively proposed by him are all characterized by anxious depressions. In our groups of agitated depressions, there is subsequent history in only five, but in three of these there were repeated attacks. In number the agitated depressions were not more than 10 cases out of 38. So far as the present group is concerned, therefore, agitated depressions are not the predominant form of manic-depressive psychoses in the presenium, nor do they seem of bad prognosis. On the other hand, they tend to recovery and recurrence.

In the table of delusions (Table III) no attempt has been made at a consistent classification. There may be some question whether the two classes mentioned last should be called delusions at all. One may call them *falsification of memory* and *apprehension*, but there does not seem to be any adequate reason for distinguishing them from delusions merely because they are not in the present tense. Six cases out of the 38 are stated to have no delusions, but as all but one of these are retarded cases, it is likely that some at least have merely failed to express their delusions. According to the table no type of delusion is much more frequent than others.

Only six of the delusions mentioned are evidently absurd; these are:

- 1888. Is God, king of China, Pope.
- 1754. Family is Holy Family.
- 269. Sun is heaven.
- 388. Face isn't right—is frozen stiff, can't get heat into body.
- 553. Evil spirit in belly.
- 1842. Everything wrong inside body. Is chased by six spiders by night and six spiders by day.

TABLE II.—MANIC-DEPRESSIVE CASES ANALYZED AS TO COURSE.  
(Subsequent history from other hospitals. Status on discharge from the Psychopathic Hospital not considered.)

Group.	No.	Sex.		Previous attacks.	Subsequent attacks.	Subsequent history.	Recovered.	Improved.	Stationary.	Died.
Manic .....	8	3	5	5	0	6	2	2	2	
Depressed retarded ...	14	6	8	4	1	6	2	2	1	1
Depressed agitated ....	8	1	7	0	3	5	1	3	1	
Depressed not ret'd or agit.	6	3	3	2	1	4	1	1	1	1
Depressed ret'd and agit. ...	2	0	2	0	0	1	0	0	0	1
	<u>38</u>	<u>13</u>	<u>25</u>	<u>11</u>	<u>5</u>	<u>22</u>	<u>6</u>	<u>8</u>	<u>5</u>	<u>3</u>

TABLE III.—ANALYSIS OF DELUSIONS MANIC-DEPRESSIVE CASES.

Group.	No.	Cases with no delusions.	Somatic.	Persecutory.	Self condemnatory.	Grandeur.	Impersonal.	Referring to past or to future.	Apprehensive.	Hallucinations.
Manic .....	8	1	1	2	0	3	1	2	1	3 all questionable.
Depressed retard..	14	5	3	3	4	0 (grotesque)	1	0	3	1 questionable.
Depressed agitated .....	8	0	1	4	4	0	0	0	4	2
Depressed ret. and agitated ..	2	0	1	1	1	0	0	0	0	0
Depressed not ret. or agitated.	6	0	3	2	0	1	0	0	1	1
	<u>38</u>	<u>6</u>	<u>9</u>	<u>12</u>	<u>9</u>	<u>4</u>	<u>2</u>	<u>2</u>	<u>9</u>	<u>3</u>

(possibly 7)



The first three of these occurred in maniacal cases, and are plainly quite different from the last three, which were found in depressed cases. The latter also suggest strongly perversions of the sensory apparatus.

Hallucinations play a very small part in the manic-depressive group. They are clearly present in three cases (882) "little voices inside," (1768) "auditory hallucinations," (772) "voices in stomach reveal things." The two in which the content of the perceptions is mentioned are thus somatic. It will be noticed also that these somatic hallucinations like the somatic delusions in the depressed cases mentioned above are also absurd.

#### DEMENTIA PRÆCOX.

In 27 cases of mental disorder appearing after 40, the diagnosis of dementia præcox appeared justified. There were eight males and 19 females. Reports of the subsequent courses were obtained in 19 cases. Ten were still in hospitals unimproved, four years later. Three were reported unimproved four to six months after leaving the Psychopathic Hospital. They were transferred to other hospitals and the later history is unknown. Within a year after leaving the Psychopathic Hospital, four were reported improved, three being discharged and one being sent to another institution. One died of lobar-pneumonia, mentally unimproved, after two years.

Only one case was reported as definitely recovered. This was a married woman aged 54, (348). Upon entrance to the Psychopathic Hospital she was said to have been mentally disordered for about six years but "not bad until a few days ago." She was in the Psychopathic Hospital eleven days, and was then transferred to another state hospital from which she was discharged as recovered four months later. She had been addicted to alcohol but had used none for several months. She felt as if "under a spell." She complained of an electrical machine under her bed which she had heard working for years. It made her talk and yell and "drew the life out of her." She was also jealous of her husband, with what reason is not known. She was described as somewhat depressed, without any marked motor phenomena and with no insight.

The eight cases which not were followed after leaving the Psychopathic Hospital were all unimproved upon discharge. The duration of the disorder before commitment was stated as from six months to two and a half years. Delusions were expressed in 26 cases, the one exception being mute. In 20 cases delusions and hallucinations were the prominent features. In three of the hallucinated cases and in four of those in which hallucinations were not observed there were striking disturbances of conduct, stupor, fixed attitude, mutism, stereotypy, echopraxia, etc.

One case (1083) a male, aged 44, was committed to the Psychopathic Hospital after a mental illness of two months. He was depressed, had a feeling that some calamity impended, and was restless, contrary and disagreeable. He was classified as a manic-depressive, depressed phase, and after six days transferred to another state hospital. A report obtained after four years states that he has grown steadily worse and is "resistive, indifferent and with stereotyped speech."

Family history of mental disease was mentioned in only three cases of the 27. Of one (1853) the note is made, "Brothers were all abnormal, epileptics, tramps." One female (246) was the third case of insanity in the direct family line. One (273) has an insane son. Two are said always to have been peculiar.

*Summary.*—On the whole the 27 cases seem to be no different from cases of dementia præcox arising earlier in life. Most of them fit very well the Kraepelinian paranoid group. In only seven are the features commonly called katatonic prominent.

#### UNCLASSIFIED.

*Introductory.*—The chief problem of the present paper lies in the 41 cases remaining after the exclusion of the previous groups. Thirty-two of the 41 cases were females. Of the cases which were transferred to other hospitals reports of the further course were obtained in 21. In only six of these did the final diagnosis agree with that made at the Psychopathic Hospital. For the sake of brevity, the 21 cases are shown in tabular form.

It will be noticed that some of the cases in the group of 41 have been assigned either at the Psychopathic Hospital, or another hospital, to one of the groups previously considered. It has been my intention to include in those groups only the cases which from symptomatology and course appeared pretty certainly

TABLE IV.—UNCLASSIFIED CASES IN WHICH SUBSEQUENT HISTORY WAS OBTAINED.

No.	Sex.	Age.	P. H. diag.	Final diag.	Outcome.
505.	F	58	Unclassified	Paranoic Cond.	4 yrs. later not imp.
412.	F	51	"	Manic-Depr.	7 mos. later improved.
1016.	M	55	"	D. P. Heb.	17 days later died purulent leptomeningitis.
1268.	F	50	Presenile	Manic-Depr.	8 mos. recovered.
1059.	F	55	"	Invol. Melanch.	4 yrs. later improved.
1475.	F	40	"	Paranoic Cond.	1 mo. later discharged "capable of self-support." One mo. later died rupture aneurism int. carotid artery.
1240.	M	46	Man. Dep.	Invol. Melanch.	1 mo. later died pyæm.
593.	F	51	D. P. P. or Invol.	Manic-Depr.	4 yrs. in hosp. not imp.
748.	M	47	D. P. P.	Psychasthenia	
			Psychosis		9 mos. discharged rec.
1476.	M	50	D. P. P.	Invol. Melanch.	1 mo. discharged imp.
667.	F	45	D. P. P.	Paranoic Cond.	9 mos. capab. self-sup.
1207.	F	48	D. P. P.	Manic-Depr.	11 mos. recovered.
825.	F	43	D. P. P.	Unclassified	9 mos.
1156.	F	53	Paraphrenia		
			Confabulans.	Paranoic Cond.	2 yrs. not improved.
439.	F	59	M. D. D. Invol.	Involuntional	1 yr. improved.
1992.	F	53	Unclass. Par.	Paranoic Cond.	4 yrs. not imp., in hosp.
606.	F	55	Unclass. Par.	Paranoic Cond.	4 yrs. improved.
155.	F	49	Paranoic Cond.	Paranoic Cond.	1 yr. not improved.
	F	51	Involuntional	Involuntional	4 yrs. not improved.
287.	M	58	Unclass. Depr.	Unclass. Depr.	10 mos. not improved.

The 20 cases which were not followed after they left the Psychopathic Hospital received the following diagnoses :

Unclassified .....	6
Unclassified depression .....	4
Paranoic condition .....	3
Dementia præcox .....	2
Manic-depressive .....	4
No diagnosis .....	1

to belong there. It is on account of a lack of these characteristics that the present group has been excluded. Some of the cases perhaps present too few facts to be of much value. Others are, according to the standard mentioned, too anomalous. While the data at hand, as mentioned earlier under the heading of "Nature of Material" are sufficient to admit of placing typical cases in their respective groups, they are by no means adequate for the establishment of new groups. Such an undertaking should properly demand not only a minute and extensive study of course and symptomatology in a large number of cases throughout life with psychological analysis of the individuals, but also thoroughgoing studies of pathological anatomy. Kraepelin's tentative and rather apologetic study of presenile psychosis with its inconclusive results gives an indication of the difficulties to be met in this field.

While our facts are too meager to allow any attempt to establish groups, they are of practical service in at least one particular, namely, prognosis. It is of value also to find out what correlations there may be between a good or a bad prognosis and other data, such as character of delusions, hallucinations, affective state and psychomotility.

In addition to the 21 cases with subsequent history shown in Table IV, there was one case which died at the Psychopathic Hospital and three cases in which the mental disorder had begun more than two years before admission. Although the latter course of these is not known they can with advantage be included in the former group.

Of the 25 cases, five died, four were discharged as recovered, seven are said to be improved and nine were at the latest report "not improved." These four groups will be considered separately.

#### CASES DEAD.

1016.—Male 55, unmarried. Duration given as two months. Always queer. Thinks he has been ill-treated. Fears he has been poisoned, food is tampered with. He has been kidnapped. He has to go to hell. Memory all gone (not true). Has been ruined by masturbation; talkative about himself, depressed. Pupils small and irregular, react to light and upon accommodation. Slightly deaf. Peripheral arteries hard and tortuous. Cause of death, *acute purulent meningitis*.

723.—Female 52, unmarried. Duration 15 months. Insists that house in which she rooms belongs to her. Physicians are representatives of police sent to annoy her. Physicians are representatives of police sent to

annoy her. Makes vague accusations against relatives. Not depressed, not euphoric. Aggressive, verbose, mildly excited at times. Cause of death, *rupture of aneurysm of internal carotid artery*.

349.—Male 52, unmarried. Duration three years. "Back fence is falling; stove is falling apart; shelf is falling on wife"; people are trying to injure him. Depressed, restless, later inactive, excessive alcoholism previous to 10 years ago. Eczema on hands and forearms (pellagra?). Cause of death, *broncho-pneumonia*.

1240.—Male 46, duration four months. Shunned company, thought he was to be injured; says "don't torture me." Depressed, apprehensive, restless, resistive, somewhat retarded. Cause of death, *pyemia*.

1552.—Female 48, married. Herself and husband persecuted by father and family. Bed on fire, food poisoned, auditory hallucinations. Flight of ideas. Depressed. "Katatonic state, negativistic, later very active." Died, *acute dilatation of heart*.

#### CASES RECOVERED.

825.—Female 43, unmarried. Duration one year. Delusions of persecution and reference. Auditory hallucinations. Emotionally apathetic. No katamenia during three months of observation.

1207.—Female 48, unmarried. Duration three years. A client of her lawyer made slanderous remarks about her. Friends of this man and strangers call out names as she goes by. Slightly depressed, quiet and listless. Menopause at 47.

748.—Male 47, widower. Duration about three years. "Is watched and spied upon." Thinks he is killed, and deserves to die because of wife's death from abortion. Auditory hallucinations. Worried, irritable, agitated, seclusive. Uses alcohol moderately.

1268.—Female 50, married. Duration one year. "People look strange" to her. Neighbors make remarks about her. Apprehensive of harm. Thoughts transferred to others by telegraphy. Does not appear depressed.

#### IMPROVED.

412.—Female 51, unmarried. Duration when last reported one year. "Snake confined in bowels," referred to right hypochondrium. It is put there for punishment. Sees a snake before face with glaring eyes. Mood said to be "pleasant." Constipation, tenderness at caput coli. Psycho-analyzed by L. E. Emerson, who elicited a history of illegitimate son and incest. Discharged improved.

1475.—Female 40, unmarried. Duration when last reported seven months. Injured by authorities at St. Elizabeth Hospital. Nurses guilty of all sorts of misdemeanors, starve her, drag her by arm and hair, police officer tried to disgrace her by putting arm on back of seat, querulous. Discharged capable of self-support.

1476.—Male 50, married. Duration not given. Fellow-workmen make him drowsy, weak and suffocating. He is watched through partition, is

persecuted by members of some society who drop poison in food, and liberate gas in air. Depressed. Discharged improved.

667.—Female 45, single. Duration three years when discharged. Persecuted by police, prevented from getting work. Had complained to authorities. Exhilarated, restless. Discharged capable of self-support.

439.—Female 59, married. Duration to discharge 15 months, fears she has done wrong and cannot be forgiven. Depressed, agitated. Discharged improved.

606.—Female 55, married. At present in hospital, duration eight years. Thinks she has tuberculosis, is going to be killed. Felt son was in hospital. Hears people talk about her behind her back. They say she has tuberculosis. Depressed, quiet, menopause two years after onset. Condition improved.

763.—Female 45, married. Duration at last report two years. Thinks she is being robbed, health is gone. Has a "terrible feeling." Depressed, menses irregular for last year. Improved on discharge.

#### CASES UNIMPROVED.

1992.—Female 53, married. Duration at last report eight years. People injure her floors, boards are opened up, chairs pulled apart, clothes torn up. Not depressed or elated. Menopause at 50. Fine tremor of hands and facial asymmetry.

505.—Female 58, married. Total duration four years. Thinks she is pregnant and that a moving pain in her chest is due to a child. She saw a vision in a crystal which led to this belief. Eats excessively and takes food to bed. Quiet and indifferent.

521.—Female 51, unmarried. Duration five years. Policemen watch and follow her. She is in love with a policeman whom she has never met. Everybody seems different in the last two years. She hears voices of policemen making love to her, of the police matron and relatives. She has seen God and had other visions. She was at first depressed but afterwards unconcerned.

1059.—Female 55, married. Duration six years. Her children have been arrested and are held on Deer Island (not true). Thinks she is to be put into an institution. Depressed and agitated. Is tremulous and complains of pain about head and heart.

287.—Male 50, unmarried. Duration at last report 15 months, when was sent to a hospital for chronic cases. No definite delusions. Complains of "poor health," chronic indigestion. Depressed and apprehensive.

1156.—Female 53, married. Duration two years, when sent to hospital for chronic cases. Some one is poisoning her, she is hypnotized, says she is daughter of the archbishop, mistakes identities, gives fictitious names to nurses and physicians and sticks to these names. Usually good-humored, sometimes irritable, but never depressed. Talkative, laughs a good deal. Takes grotesque attitudes of devotion. Menopause at 40.

155.—Female 49, married. Thinks husband is trying to get rid of her, and that he keeps other women. He has had babies by these women and she hears them crying. Sad. Became blind six years after onset.

593.—Female 51, married. Duration four years. People follow and ridicule her, she fears that her clothes are to be stolen and that she is to be put into boiling water, "hears voices and sees visions." Depressed, groans in distress.

1386.—Female 56, married. Duration two years. She has been given pills which have caused bowels and womb to draw together. Eyes feel as if coming out of head. Her son's mother-in-law tried to poison her and poison has been put into her food at the hospital. She saw smoke from stuff burned upstairs come through holes burned in wall. Menopause at 51.

*Discussion.*—In the attempt to find something characteristic in the 41 "unclassified" cases, by separating according to course those which offered facts for such an analysis, it is obvious that the four groups which have just been abstracted are not of equal value for the purpose.

Taking up the groups in order, we may first consider the five which died. In cases 1552 and 1240, the cause of death is apparently least likely to have anything to do with the psychosis. The latter appears however to be the only one allied to the severe agitation with quickly fatal outcome described by Kraepelin, as his first group under the caption of Presenile Psychosis. As to the other three cases it is very striking that there is in all a possible relation between the cause of death and the psychosis, although the facts are too meager for certainty.

1016. Total duration seven weeks. Purulent leptomeningitis.

349. Duration three years. Broncho-pneumonia, possibility of pellagra.

725. Duration 12 months. Aneurysm of internal carotid (arteriosclerosis).

The four cases which recovered were not at first considered of good prognosis. Three of them were called dementia præcox, paranoid form, and one "presenile psychosis," but upon review at the Boston State Hospital these diagnoses were changed. Only one (747) had any marked affect, depression with agitation, and this was the only one with self-condemnatory ideas. The other three had delusions of persecution and reference, and one of them felt that her thoughts were transferred by telepathy. All of the recovered cases had auditory hallucinations. In these four cases as seen at the Psychopathic Hospital no marked features stood out by which the favorable outcome could have been predicted.

It would be difficult to draw any definite prognostic inference from the seven cases called "improved," because the term itself

is indefinite. The difference of diagnosis in the hospitals of first and second residence is very striking, as shown in the following table:

Case.	P. H. diagnosis.	Final diagnosis.
442.	Unclassified.	Manic-depressive.
439.	Manic-depressive depressed (invol.).	Involuntional condition.
606.	Unclassified paranoid.	Paranoic condition.
667.	Dementia præcox paranoid.	Paranoic condition.
763.	Unclassified depressive.	
1475.	Presenile psychosis.	Paranoic condition.
1476.	Dementia præcox paranoid.	Involuntional melancholia.

Six of these cases are depressed and one exhilarated. All have delusions, in four cases predominantly persecutory, in three self-condemnatory. Somatic delusions are present in two cases.

Reference to the nine cases which were at the last report unimproved, shows that all but one were females and that the one male is the only one not deluded. In the terminology of Wernicke allopsychic delusions were expressed in seven cases, autopsychic in four and somatopsychic in two. Two patients expressed expectations of calamity, in one case of a horrible nature. Hallucinations were mentioned in three cases, but were not a prominent feature. In two the hallucinations were closely connected with the delusions. Emotional states were,

Depressed (155, 287, 1385).....	3
Depressed with agitation (593, 1059).....	2
"Normal" (1156, 1992).....	2
Depressed—later unconcerned (521).....	1
Indifferent (505) .....	1

Expectation of calamity occurred only in the agitated cases. The non-depressed cases were noteworthy for their numerous and bizarre delusions.

So far as any prognostic value is concerned, the groups of "recovered" and "unimproved" alone have any particular value. The group of "dead" will not be considered further, although the possibility that in three cases, as mentioned above, the fatal outcome was related to the psychosis and not merely accidental, adds to the prognostic value. One may perhaps consider the 24 cases which have been analyzed with respect to outcome as representative of the group of 41. But to say that the prognosis as to recovery is good in 15 per cent and bad in 37 per cent would be



giving an appearance of accuracy to what is really only a rough approximation. The duration of the psychosis up to the latest report of the case needs to be taken into account. In three of the "unimproved" cases the duration is not more than two years. Two of these, however, were transferred, after observation for a year or more at the Boston State Hospital, to a third institution as chronic cases. It is not impossible that these cases may have recovered later. The durations in the other six cases were from 4 to 11 years, so that the unfavorable prognosis in these has a high degree of probability. On the other hand the "recovered" cases might turn out to be recurrent. In fact cases 1207 and 1268 were looked upon after leaving the Psychopathic Hospital as manic-depressive, although from the abstracts given above it is difficult to see how such a diagnosis can be maintained. One wonders how far the outcome may have influenced the diagnosis. Keeping in mind then that the figures are only roughly approximate one may say that in the group of 41 cases as defined, about 37 per cent are of bad prognosis and about 16 per cent of good prognosis.

#### CLINICAL SUMMARY.

*Age and Sex.*—The entire group of 106 cases consists of 76 women and 30 men. The average ages are: women 50.0 years and men 49.3 years.

*Heredity.*—Note of insanity in other members of the family is made in 13 cases. Information is too meager to allow any further analysis.

*Alcoholism.*—Inquiry into the use of alcohol was made in 38 cases. Eighteen denied its use entirely, 14 admitted moderate use, three drank heavily and three had drunk formerly but had lately been abstinent.

*Syphilis.*—Wassermann reactions were reported in 86 cases. The blood serum was negative in 70, positive in three and doubtful in one. Spinal fluid was negative in 11 and "suggestive" in two.

*Physical Diseases and Defects* were mentioned in 25 out of the 106 cases. In some there appeared to be a possible relation between the physical condition and the mental content. These cases are as follows:

- 155. Blind, suspicious.
- 175. Pulmonary tuberculosis, threatens to infect family.
- 266. Nose itches, worms in nose.
- 412. Constipation, tenderness of caput coli, snake in right hypochondrium.
- 674. Increasing sexual impotence, bear coming to castrate him.
- 882. Vesico-vaginal fistula, police after her on account of odor.
- 939. Old operative wound, has been operated because wound reopened (not true).
- 1364. Gastric burning and pain, suspicions of poisoning.

The remaining cases are as follows :

- 87. Old operation.
- 1241, 1834. Recent abdominal operations.
- 91, 92. Heart apex outside nipple line.
- 1552. Acute dilatation of heart.
- 154, 1059, 1992. Tremors. (154 alcoholic, cause unknown in others.)
- 262. Fecal impaction.
- 269. Recent delirium tremens.
- 349. "Eczema" on hands and forearms.
- 517. Carcinoma of penis.
- 553, 1016. Pupils unequal, arteries sclerotic.
- 1066. Left divergent strabismus, left naso-labial fold flat.
- 1510. "Stricturea neurotica esophagi."

*Delusions, Hallucinations, Affect.*—If we review the 106 cases with respect to *delusions*, we find that they are stated to be absent in only eight cases. Most of these were retarded cases in which delusions might easily be unexpressed though present. Persecutory ideas were present in 78 cases, somatic in 21, self-condemnatory in 16, and in a few cases delusions of jealousy, grandeur, etc. Delusions of negation and unreality, which have received so much attention in the literature of involutional psychoses, were found, respectively, once and three times. In about half the dementia præcox cases the emotional tone is described as "apathetic" or "normal" in spite of the expressed ideas which are nearly always unpleasant and sometimes terrible.

*Auditory Hallucinations* were found in 38 cases and visual hallucinations in seven. These are divided as follows :

	Total No. cases.	Auditory hallucinations.	Visual hallucinations.
Dementia præcox .....	27	17	3
Manic depressive .....	38	7	2
Unclassified .....	41	14	2

An attempt was made to correlate hallucinations with other outstanding features of the cases, disregarding the formal diagnosis. The features chosen were emotional quality and psychomotility. A résumé of delusions divided as far as possible according to the Wernickean triad of somatic, personal and environmental ideas is also included in the following table.

	No. cases.	Auditory Visual halluci- halluci- nations. nations.		Allopsychic.		Autopsychic.		Somato- psychic.	
				Per Cent		Per Cent		Per Cent	
Depressed:									
Agitated . . . . .	21	5	0	15	58	9	34	2	8
Retarded . . . . .	13	0	0	5	35	5	35	4	30
Agitated and retarded . . . . .	5	0	0	4	59	1	14	2	29
No abnormal motility . . . . .	24	9	2	24	69	4	11	7	20
Elated . . . . .	10	4	2	2	20	6	60	2	20
Emotional state normal or in- consequential . . . .	33	19	3	3	77	6	14	4	9

It appears from the table that there is, as might be expected, a positive correlation between allopsychic delusions and auditory hallucinations. There seems also to be two definite groups in which this association occurs; namely, depressed cases without disorder of motility, and cases in which the emotional state did not correspond to the content of the delusions.

As to emotional tone, 10 of the 106 cases were described as elated. Eight of these made up the group of manic-depressive manias. Only two of them were free from ideas of an unpleasant nature. Of the two which were not grouped with the manias, one had persecutory ideas of a decidedly unpleasant nature, yet always gave the impression of exhilaration. Of the remaining 96 cases—

- 68 were depressed,
- 4 passed from initial depression to apathy or elation,
- 2 were variable,
- 6 were apathetic,
- 1 not stated,
- 15 were described as "normal" emotionally.

The ideas expressed by these 96 patients were in every case but two of an unpleasant character, ranging from delusions of the most terrible content to mild hypochondriacal ideas. In one of

the exceptions the patient was beset almost continuously by hallucinatory voices, directing her to do many things such as "not to talk English to the physicians," "to go to the toilet over and over," but never suggesting anything depressing, unless, the reassurance that "she is not crazy" be considered to have such a connotation. This patient was described as sad. The other patient without unpleasant ideas was No. 1564, described under the group with katatonic symptoms. She was described as "variable" emotionally.

The delusions and ideas in the 106 cases with respect to their quality of pleasantness or unpleasantness, and their relations to the emotional states, are summarized in the table.

CONSISTENT.			
Mood.		Ideas.	
Depressed .....	67	Unpleasant .....	67
Elated .....	2	Pleasant .....	2
INCONSISTENT.			
Elated .....	8	Unpleasant .....	8
Normal .....	15	" .....	15
Apathetic .....	10	" .....	10
Depressed .....	1	Pleasant .....	1
Variable .....	1	" .....	1
Variable .....	1	Unpleasant .....	1

*Cases with Katatonic Symptoms.*—Symptoms which might be considered katatonic were present in eight out of the 106 cases, or  $7\frac{1}{2}$  per cent. Six cases were classed as dementia præcox and two were included in the undiagnosed group.

Abstracts of the eight cases follow:

952.—Female 42, unmarried. Known duration seven months. No delusions stated. Sees face in ventilator. "Mania for burning things." Stands in one position for hours, facing blank walls. Has knelt in attitude of prayer for 12 hours at a time mute. Onset following worry over mother's death. Dementia præcox.

1066.—Female 45, married. Known duration two years. People talk about her. Thought she would die. Voices through wall say husband is going with another woman. Stuporous, tube fed. Repeats one short unintelligible sentence. Left divergent strabismus, obliteration of left naso-labial fold, duration not stated. W. R. Negative. Transferred to Danvers, April 11, 1913. To Medfield, November 24, 1914. Improved. Dementia præcox.

1085.—Male 44, married. Known duration four years. "Family try to boss him," feeling of impending calamity. Depressed, disagreeable, restless, resistive and contrary. Transferred to Westboro, April 15, 1913. Reported February, 1917, resistive, indifferent, stereotyped speech. Dementia præcox, katatonic.

1225.—Male 47, single. Known duration four years. People in shop are against him, watch him, stare at him while he eats. Suspicious of food. A hole is being bored under his bed. Hears buzzing in left ear. Apathetic, assumes a fixed attitude and stares. February, 1917, still in hospital unimproved. Dementia præcox, paranoid.

1564.—Female 45, married. Known duration three years. Thought could talk Greek, Hebrew and Gaelic as requested. Schizophasia, neologisms, resistive, echopraxia, attitudinizing, tube-fed. Still menstruating. February, 1917, still in hospital unimproved. Dementia præcox.

1853.—Male 42, single. Known duration  $3\frac{1}{2}$  years. Is responsible for aunt's death because he went away. Worried over money. Thinks continuous prayer will improve him. Depressed, agitated, pulled out hair. Strikes attitudes. To Danvers, October 29, 1913. Reported February, 1917, as indifferent, untidy, deteriorated. Diagnosis at Psychopathic Hospital, unclassified. Danvers, dementia præcox. Brothers were all abnormal, tramps and epileptics.

674.—Male 45, married. Duration four months. Wife unfaithful. Bear coming to tear out abdomen and to castrate him. People will kill him. Is cured by God. Has sexual thoughts about men and women. Depressed, anxious, "katatonic stupor." The patient is becoming impotent. Two sisters, maternal aunt and paternal grandfather were insane. Recovered. Unclassified.

1552.—Female 48, married. Duration not stated. Father and his family persecute her and her husband. Her bed is on fire, and the food is poisoned. "Auditory and olfactory hallucinations." Flight of ideas, katatonic state and negativistic, later very active. Died, "acute dilatation of heart."

Only one of these cases (1085) was given a final diagnosis of dementia præcox katatonic. The initial stage had been such as to suggest a manic-depressive depression, and this was the diagnosis at the Psychopathic Hospital.

Case 1853 was left undiagnosed at the Psychopathic Hospital but the final diagnosis at Danvers was dementia præcox, although nothing was ventured as to the form of the psychosis. Case 1564 showed the greatest development of katatonic signs, although here again the final diagnosis (Boston State Hospital) was not specific as to form. In case 1225, dementia præcox paranoid (Psychopathic Hospital and Boston State Hospital), the katatonic-like features may possibly be explained upon an ideational basis. Case

1066 is somewhat doubtful on account of the unexplained neurological signs (ocular and facial). However the subsequent diagnosis at Danvers affirmed the earlier one of dementia præcox, without reference to organic features. Case 952 has been placed in the dementia præcox group with doubtful propriety. The strongest evidence in this direction is the katatonic features. Case 674 presents a curious medley of signs, and resembles more the late katatonia of Urstein than others in this group. Case 1552 is somewhat similar. Both these cases were considered manic-depressive at the Psychopathic Hospital, but on account of the anomalous features have been placed in the unclassified group for the purpose of the present paper.

As to the outlook in cases with katatonic features we find that only one is stated definitely to have recovered (674). One patient died (1552) and one (952) was not followed after leaving the hospital. The remainder were still in hospitals several years later, two (1066, 1225) being somewhat improved, while the three (1085, 1564, 1853) were not improved or were definitely worse.

*Prognosis.*—Later reports have been obtained of 64 of the cases which were transferred from the Psychopathic Hospital to other state hospitals. These reports are summarized as follows:

Recovered .....	10
Discharged improved .....	13
Discharged unimproved .....	1
Still in hospital improved.....	7
Still in hospital unimproved.....	25
Dead .....	8

The recovered cases were under observation for periods up to 3 years 10 months, as follows:

Less than 1 year.....	3
From 1 to 2 years.....	2
From 2 to 3 years.....	1
From 3 to 3 years 10 months.....	4

Four of the patients had recovered from repeated attacks. Two of these are included in the "over three years" group.

The cases which were discharged improved had been under observation:

Less than 1 year.....	2
From 1 to 2 years.....	8
From 2 to 2 years 9 months.....	3

Three of these cases had more than one attack.

The cases which at last report were still in hospital, but improved, had been under observation for the following periods:

2 to 3 years.....	1
3 to 4 years.....	2
4 to 5 years.....	1
6 years .....	3

Two of these were repeated attacks.

The duration of the cases which at last report were still in hospitals unimproved is as follows:

Less than 1 year.....	3
1 to 2 years.....	2
2 to 3 years.....	1
3 to 4 years.....	3
4 to 5 years.....	10
5 to 6 years.....	1
7 years .....	2
8 years .....	1
11 years .....	2

Only one of these cases had recovered from a previous attack.

The condition upon discharge from the Psychopathic Hospital of cases upon which there is no later report is as follows:

Recovered .....	4
Improved .....	12
Unimproved .....	14
Not mentioned .....	12

In estimating the value of the reports of the later condition of the patients, the length of the period of observation must be considered. The group "in hospital improved" is much more informative in a sinister sense than is the "discharged improved" group in a favorable sense, not only because of the obvious fact that they were not well enough for discharge, but also because of the much longer average hospital residence of the former group. (The averages are, roughly: "in hospital improved," 4.5 years, "discharged improved," 1.3 years.) In fact it would probably be better for practical purposes to separate the cases which had been three years or more in hospital and consider them as unfavorable. This would give 25 cases out of the "still in hospital" classes to be so considered. The value of the 10 "recovered" cases is minified somewhat by the fact that four of these have had

more than one attack, so that the "recovery" refers to the attack, but does not relieve from expectancy of other attacks.

It would give a better idea of probabilities to state the cases with repeated attacks separately. We should have then:

Recovered .....	3
In hospital 3 years and over.....	23
Dead .....	8
Improved—in hospital under 3 years.....	11
Unimproved—in hospital under 3 years.....	6
Case with recurrent attacks.....	10

### SUMMARY.

1. A statistical review of clinical data in certain cases with onset between 40 and 59 is presented. Cases with gross brain disease or known exogenous causal factors are excluded.

2. The cases are drawn from Psychopathic Hospital admissions which have been shown to include about 20 per cent of cases which would not reach a state hospital for insane. The group therefore is a fair collection of mental disorders as they actually occur in the community.

3. The use of the age-period as viewpoint is an advantage in method; in that, it (1) emphasizes epochal characteristics, (2) is inclusive, and (3) eliminates minor errors in the statement of ages.

4. A previous study of 6000 consecutive admissions to the Boston Psychopathic Hospital has shown that (1) in the 5th and 6th decades, no particular diagnostic group is numerically predominant; and, that (2) within these decades "undiagnosed" and "unclassified" forms are twice as frequent as in the 6000 cases without respect to age.

5. In the present study 2000 consecutive admissions to the Boston Psychopathic Hospital have been reviewed. Three hundred and forty-five were between 40 and 59 years. The following classes were excluded: Continuous or periodic disorder beginning before 40; diseases with known exogenous cause (alcohol, syphilis, etc.); senile and organic cases. The residue of 106 cases forms the material of the paper.

6. The data utilized included the usual personal facts and physical and psychiatric examinations from the case records, the diagnosis, and in about half the cases a report, obtained from



various Massachusetts state hospitals, of subsequent course and later diagnosis after from one to five years.

7. A striking feature of the special group as defined in paragraph 5 is that nearly 72 per cent are females. Of all cases in a series of 6000 admitted between 40 and 59 (without regard to diagnosis) 45 per cent are females.

8. Sixty-five of the 106 cases could be placed definitely into the two groups of manic-depressive psychosis and dementia præcox. These diagnoses depend upon: (1) The opinions of the Psychopathic Hospital staff, which in a large proportion were (2) confirmed by the staff of the hospital to which many of the cases were later assigned, and (3) upon review of the cases in the light of all the obtainable facts. In a few instances review of the cases led to a change in the earlier diagnoses. Forty-one cases were not easily classified.

9. Of the 38 manic-depressive cases with onset after 40, 10 were of the manic type and 28 were depressed. The "agitated depressions" numbered 10 cases.

10. There was history of more than one attack in 16 out of the 38 manic-depressive cases. (No cases were included in this study if the first attack occurred before 40.)

11. Twenty-two of the manic-depressive cases were followed from one to five years after observation at the Psychopathic Hospital. Only five had neither recovered nor improved.

12. The diagnosis of dementia præcox was made in 27 out of the 106 cases.

13. The subsequent history of 19 dementia præcox cases was followed. Ten were in hospitals unimproved four years later, one died unimproved two years later, three were reported unimproved six months later. Four were reported to be improved, and one case was said to be recovered after the mental disorder had lasted over six years.

The eight dementia præcox cases without subsequent history were all unimproved upon discharge after duration of from six months to 2½ years.

14. In 41 cases the diagnosis was not clear, not confirmed by a second hospital, or upon review the cases appeared too anomalous to allow classification under the usual groups.

15. These 41 cases are reviewed with respect to a prognosis, on the basis of the 25 cases in which subsequent history is known. Five cases died, four recovered, seven improved, and nine remained unimproved.

16. In the five cases which died there was a possible relation between the psychosis and the cause of death in three.

17. The four cases which recovered showed no features at the Psychopathic Hospital by which the favorable outcome could have been predicted.

18. In the entire group of 106 cases information as to the use of alcohol is given in 38. Three drank heavily and 14 moderately. Alcohol seemed in no case to have any noticeable effect upon the psychosis.

19. The blood serum was positive by the Wassermann reaction in three cases and doubtful in one case out of 74 tested. Cerebrospinal fluid was "suggestive" in two cases and clearly positive in none, out of 13 tested. The cerebrospinal fluid in two cases with positive sera was negative. The third was not tested.

20. In 25 cases out of the 106 there were obvious somatic diseases and defects. In eight cases these were reflected in the psychotic picture, and in 17 there was no evident connection.

21. Delusions were expressed in 98 of the 106 cases. Most of the eight exceptions were *retarded* cases. Persecutory delusions were expressed 78 times, somatic 21 times, self-condemnatory 16 times and jealousy, grandeur, etc., a few times.

22. Delusions of negation were found in one case, and delusions of unreality in three.

23. Auditory hallucinations were described in about two thirds of the dementia præcox cases, one-sixth of the manic-depressive cases and one third of the unclassified groups.

24. There is a positive correlation between auditory hallucinations and allopsychic delusions in two definite groups of cases: (1) Depressed cases without motility disorder, and (2) cases in which the emotional state did not correspond to the content of the delusions.

25. As to emotional quality, 10 cases were elated, 68 were depressed, 15 were said to be "normal," six were "apathetic," two were variable and four passed from initial depression to final apathy or elation.

26. The expressed mental content of 102 out of the 106 cases

was of an unpleasant character, ranging from the most terrible delusions to hypochondriacal ideas.

27. Of the 10 cases which were continuously euphoric, only two were free from ideas of an unpleasant quality.

28. The emotional quality of the ideas and the emotional expression were consistent in 69 cases and inconsistent in 36.

29. Katatonic symptoms were present in eight cases or  $7\frac{1}{2}$  per cent. One of these is said to have recovered, one died, one was lost sight of and the remainder were still in hospitals several years later.

30. The outcome on the 64 cases in which reports from subsequent hospitals are available is as follows:

Recovered .....	6
Cases with recurrent attacks.....	10
Improved—in hospital less than 3 years.....	11
Unimproved—in hospital less than 3 years.....	6
In hospital 3 years and over.....	23
Dead .....	8

31. A large proportion of the 36 per cent upon which there is no later hospital history belongs to the non-institutional class reached especially by a psychopathic hospital. The condition on discharge is stated in 30 out of the 42 cases of this group. Sixty per cent were improved or recovered.

### CONCLUSIONS.

A review of psychoses from psychopathic hospital material, which arise in the 5th and 6th decades and are not due to gross brain disease nor to exogenous factors permits the following conclusions:

1. About 60 per cent can be classified as manic-depressive or as dementia præcox.
2. Cases with agitated depression, delusions of unreality and of negation, and with katatonic features are relatively uncommon.
3. Delusions of unpleasant content are characteristic and are almost invariably present.
4. In a large proportion (34 per cent) the prevailing mood is inconsistent with the ideas expressed.
5. If recurrent cases are counted as favorable the prognosis is good in about 25 per cent.

Excluding recurrent cases, an absolute recovery was reported in 10 per cent of 64 cases with later history.



## RECENT AMERICAN CLASSIFICATIONS OF MENTAL DISEASES.

By E. E. SOUTHWELL, M. D.

The American Medico-Psychological Association has now adopted a classification of mental diseases which appears in general to be a highly satisfactory classification. This new standard American classification has been drawn up with the interests of district state hospitals largely in mind and is in some respects not suitable to the somewhat broader material confronted by the general practitioners and by the staffs of psychopathic hospitals. It is with the interests of general practice and of psychopathic hospital practice that I have been in recent years busy in the matter of early diagnosis. Accordingly, it was with great interest that the classification presented by the highly competent committee of the association was greeted by those of us who had to do with the task of diagnosing the "incipient, acute and curable" group of mental diseases flowing through the psychopathic hospital wards and out-patient departments. It was with the last two groups (21 and 22 of the American Medico-Psychological Association's classification) that psychopathic hospitals obviously had most to do, namely, with the so-called "undiagnosed psychoses" and the so-called "not insane." Whereas the Association's committee evidently regards the group of "undiagnosed psychoses" as a comparatively small one and specifically states that the "not insane" group should receive the occasional cases which, after investigation and observation, give no evidence of having had a psychosis, it is clear that psychopathic hospitals and out-patient departments will always find at least a minority of their cases in one or other of these groups of "undiagnosed psychoses" or "not insane." It appears likely therefore that future developments in mental hygiene with the establishment of psychopathic hospital facilities attracting great numbers of "incipient, acute and curable cases" into the psychiatric circle, will require some corresponding developments in the American Medico-Psychological Association's classification. The American

Medico-Psychological Association's classification appears in short to be one dealing with the insane in the committable sense and not with psychopaths in the broader sense of modern mental hygiene. The committee terms this last group, namely, the "not insane," a group in which it is determined that no psychosis existed. It is doubtful whether the association committee should use the term psychosis in this narrow sense of a disease suitable for care in hospitals for the insane. It ought to be a task of this continuing committee, at least in the writer's opinion, to arrive at a decision whether the term psychosis should be used as equivalent to medicolegal insanity (in the sense of at least potentially committable "certifiable") or whether the term psychosis should be used in a broader sense to cover cases of mental disease which are not even potentially committable. In our local Boston Psychopathic Hospital practice, we have fallen into the habit of specifying, in all instances where there can be the slightest doubt, whether we are dealing with,

A, a psychosis, committable,

B, a psychosis, not committable, or

C, a psychopathic condition too ill defined to warrant the term psychosis.

And beyond these psychopaths might be

D, a group of eccentrics or anomalous persons who only concern the psychiatrist remotely, amongst whom might be found, *e. g.*, many of the so-called defective delinquents. Whatever the decision in this matter, it is clear that the vistas of diagnosis opened out by psychopathic hospital practice are far deeper than those of district state hospital practice in its usual sense.

Of course, the practising neurologist, who was in effect all the time a kind of psychiatrist, had always to deal with this penumbra of psychiatric diagnosis, and practical alienists in the medicolegal sense of that term had in point of fact to be the most delicate observers in the world of just these nuances of psychiatry.

But one should not find so small a fly in the ointment of the new American Medico-Psychological Association's classification, and it would appear to me that in the course of a very few years, especially with the stimulation afforded by the neuropsychiatric problems of the war material, the American Medico-Psychological Association's classification will be whipped into a still more generally applicable shape.

Our own problem in the field of diagnosis of the "incipient, acute and curable" group was not so much the nature and conditions of a classification as the method by which one should most speedily and accurately arrive at a diagnosis. It was not so much the nature and number of the entities in question as the process-types of their diagnosis that formed the new task of the Psychopathic Hospital. Again, let me insist that by calling the task new, I do not mean to say that it is not in one sense a problem as old as the hills, confronting every general practitioner, every consulting neurologist and every specializing medicolegal alienist; but the problem is new in the sense that hardly any institutions in America, except the Psychopathic Ward of the University of Michigan at Ann Arbor, and the Psychopathic Hospital in Boston, had been so equipped as to confront a large mass of material with all modern diagnostic weapons. For, despite the relative accuracy and practical moment of the results attained in institutions like the Bellevue Hospital Psychopathic Ward and the Psychopathic Ward in Cook County, Illinois, it cannot be said that these institutions had been supplied by the local governmental authorities with enough means and large enough staffs to do justice to modern methods.

Again, let me insist that I do not decry the efforts of local governments in establishing such institutions as the Bellevue and Cook County institutions, which in their practical way may accomplish as much as or even more than institutions which are theoretically and scientifically better off. Nor can I think of any means of sharpening psychiatric diagnosis better than a four or six months' course in contact with the mobile and polychromatic material passing through the New York and Chicago institutions mentioned. However, in the interests of mental hygiene it seems that the local governmental authorities should strengthen such institutions as these by enlarging their staffs, greatly developing their laboratories, and immensely extending their social services. The tasks confronted by the four institutions mentioned, two of which have been properly equipped from the scientific point of view and two of which have served their practical turns even better than could have been expected, are tasks of diagnosis that any attempt at classification must take into account.

Stimulated by this problem in mental hygiene, a problem really of the greatest magnitude for almost everybody's future, and stimulated by the progress made by the American Medico-Psychological Association's committee on statistics, I examined recent American text-books of psychiatry with the aim of learning how many entities were considered by competent psychiatrists really to exist. I had blocked out a paper dealing with these classifications, anticipating most interesting divergences of opinion and hoping to learn something from the mutual critique which the various classifications would afford. There had indeed been a certain healthy disputatiousness in recent American psychiatry, or at least an interesting appearance of acrimony, which led one to hope much from a study of these supposed divergences of opinion. In point of fact, I found extraordinarily few genuine divergences. There were, to be sure, divergences of nomenclature and there are many amongst us who hardly distinguish between nomenclature and classification; but setting on one side nomenclatural questions, the actual and fundamental differences which can be found, *e. g.*, in a comparison of a text-book by Dercum with a text-book by White, are singularly few. I was somewhat disappointed to find so little actual theoretical controversy in American psychiatry. The only sign of healthy competition in hypotheses is to be found in the Freudian discussions which are certainly acrimonious enough, little as they frequently attack the central and underlying problems at stake. But, aside from the small Freudian unpleasantnesses, there is singularly little viable controversy over psychiatric theory in recent American work. Accordingly, I gave over my projected analysis of the supposed divergences in American theoretical psychiatry as shown in the favorite text-books (amongst which may be mentioned DeFursac in Rosanoff's latest modified edition; Dercum; Diefendorf; Knapp in Strümpell's "Practice of Medicine"; Peterson in Church and Peterson's Text-book; and White), and can only report the extraordinary unanimity above mentioned, a unanimity which was doubtless at bottom the reason why the Medico-Psychological Association could so readily bring about an adoption of its classification. Whatever anybody's doubts as to the details thereof, the classification could certainly be practically used. I hope only, from the point of view of general develop-



ments in mental hygiene, that the committee will be a truly standing and dynamic committee, ready to consider year by year modifications which may be proposed, to the end that possibly at the expiration of either a hemi-decade or a decade, the classification may be revamped.

But how shall any classification of mental diseases be employed? How shall we approach the classifying of mental diseases, as we, for example, approach the classification of an unknown plant or animal? What are the processes employed in actual diagnosis aside from the methods of collecting data and observation? This is no merely academic task. It has been the daily task of the Psychopathic Hospital in Boston during the last six years and in the practical handling of over 10,000 cases, a large minority of which are decidedly doubtful as to their place in any psychiatric nosology. This task must also be very prominent, as indeed the reports of these institutions show, in such hospitals as the Psychopathic Ward at Ann Arbor, the Bellevue Psychopathic Ward, and perhaps to a less extent in the Psychopathic Hospital in Cook County, Illinois. After the youthful aspirant to honors gets over his initial confusion at variations in nomenclature and becomes cognizant of the chief constituents of psychiatric nosology by their actualities if not by their names, how shall he consolidate his progress and generalize his diagnostic method? It is somewhat in psychiatric diagnosis as in the learning of an intellectual game, such, for example, as chess: the early difficulties as to nomenclatural variations correspond to the initial difficulties in learning the names and movements of chess men, but this superficial and early difficulty in chess is speedily replaced with difficulties of an entirely different logical nature.

The chess enthusiast now reads chess books, goes over game variations, studies openings and endings, and tries to become an accomplished chess player through transfer of book knowledge to his practice. In this effort he naturally, as in all other departments of science and art, always fails. He then acquires through practice, with continual reference to books or authorities, that measure of true chess knowledge which he is able to attain. He now becomes equipped with certain chess fundamentals, not too easy to reduce to propositions, although some endeavor has recently been made to accomplish this even in that most complex of all games—chess.

The medical problem of diagnosis in mental disease resembles more closely the process of classification of plants and animals than it does the choice of lines of play in chess. Probably in a later stage of psychiatric science, we shall find, in the choice of therapeutic terms and in their pragmatic modifications, much more of an analogue to the difficulties of chess.

But, it may be asked, how is it possible to reduce the classification of mental diseases to such simplicities as now run in botany or zoology? One could not hope for quite the definiteness which prevails in the taxonomies of biology when one has to deal with any form of disease, let alone the mental diseases. Still, after all, the distinction between genera and species is a distinction which is not at all confined to botany and zoology, but is a most ancient logical distinction, found at least as early as the Greek logicians. Heads and sub-heads have been known to all thinking persons since thinking persons arrived on the scene.

Out of purely practical considerations, there was developed from the Psychopathic Hospital experiences what I termed a "Key to the Practical Grouping of Mental Diseases," published in the *Journal of Nervous and Mental Disease* for January, 1918, in which mental diseases were divided roughly into 11 great groups, corresponding somewhat accurately to the so-called botanical or zoological "orders." Above I mentioned the fact that some persons do not readily distinguish between nomenclature and classification and consider that, where there are many nomenclatural divergences, there are also many divergences in classification. I said that facts proved, on analysis of leading American psychiatric text-books, that despite sundry differences in nomenclature, their classifications betrayed an extraordinarily single mind on the part of American psychiatrists. Now I find that other persons, who shall also be nameless, find it difficult to distinguish not only between nomenclature and classification, but between classification and a key to a classification or the method by which a classification is used.

Conceding that the American Medico-Psychological Association's classification, adopted as it has been by a great number of American institutions and by the United States Government for war purposes, is a reasonably good classification and aware that its constituent elements fairly well correspond with what all

American psychiatrists fundamentally agree upon, the problem still remains, how shall this classification be used; how shall we arrive at the result that a given case falls into one of the 22 groups listed by the Association's committee?

Again I find that, just as some persons fail to distinguish nomenclature and classification and others fail to distinguish classification and key, so still others fail to distinguish between the process of diagnosis and the process of collecting facts upon which a diagnosis is grounded. I find no special divergences of opinion on the part of American psychiatrists as to the methods of observation; that is, the art of collecting data of observation. To be sure, there is one eminent neurologist who triumphantly proclaims that he knows really no one or hardly any one who can take a knee-jerk; but this kind of claim of superiority in the art of observation is hardly to be endured save by some process of cleverly adapted ridicule. There is really no important split in the psychiatric world upon the methods of collecting data. Even the perennially diurnal methods of collecting a clinical history, recommended by the Freudians, do not logically differ from the scandalously inadequate cheese-boring methods adopted by the unregenerate psychiatrist of every-day life.

Suppose then that,

A, nomenclatural divergences be for the moment forgotten; suppose that,

B, some classification, *e. g.*, the A. M.-P. A.'s classification, be accepted as containing all the constituents wanted for statistical tables; and suppose that,

C, the collectors of data are duly making proper observations according to modern standards, there will still remain the question of the process of logically arriving at a diagnosis; that is, a diagnosis of the entity to which the case may be supposed to belong.

I find, however, that there are some persons who choose to deny that there are any psychotic entities and presumably that there are any pathological entities whatever. The term entity for these persons appears to have some bristling dread arcanum about it, having a smack of metaphysics; inasmuch as every individual is, through the fact of his being an individual, so very different from every other individual, how can we compress him

into an entity? Shall we not do him therapeutically an enormous injustice by subsuming him under any head whatever? Here, in my opinion, is an extraordinary overdevelopment in application of the principle of identity of indiscernibles. Was it not Leibnitz who proved or proclaimed that no two leaves of grass were identical with one another? By the same token, should we not all agree that no two persons and, *à fortiori*, no two psychopaths are at all alike? And does not this assertion mean that we cannot put any two psychopaths into one entity? This is not the place in which to discuss the inner spirit of the principle of the identity of indiscernibles; but I confess that those persons who overemphasize the principle of individualization are to my mind just as little at ease in the logical world as those who are forever generalizing. Without further argument, therefore, I want to say that I have no objection to any entity whatever, provided there is a good argument in the general psychiatric mind for its existence.

The argument in my brief paper entitled "A Key to the Practical Grouping of Mental Diseases" was an argument for an application of the original principle of order, a principle which has been greatly developed in modern logic. I have put a few historical remarks upon this matter in a paper to be shortly published in the *Journal of Clinical and Laboratory Medicine*, entitled "*Diagnosis per Exclusionem in Ordine: General and Psychiatric Remarks.*" In this paper I have called attention to the late Professor Royce's remarks upon the principle of order in modern logic and have given some reasons why it seems to me an important thing for medical diagnosis to follow this modern line of logical developments. It will be wise, however, to emphasize in this inductive age that the considerations in the paper called "A Key to the Practical Grouping of Mental Diseases" were born in practice and not in books of logic. The fact is, that in mental diseases there are few or no reliable indicator symptoms. I have tried to develop this point somewhat more in detail in a paper "On the Genera in Certain Great Groups or Orders of Mental Diseases" presented before the Neurological Association and to be shortly published. The fact that there are practically no indicator symptoms of particular mental diseases led me to be able to say to the neurologists the following: "Let a young diagnostician of the dogmatic or slightly paranoid type get the

initial idea that a case belongs in the dementia præcox group, he will be able to defend his thesis against all comers by the use of symptom lists founded upon the very best text-books. In fact, the better the text-book, the easier for the young tyro to carry his point—for the time being."

In short, if we attempted to use in the field of psychiatric diagnosis any such scheme as that of the "presenting symptoms" of Richard Cabot's formulation, we should land in quagmires of classification. For any presenting symptom, *e. g.*, mania, depression, grandiosity, delusion, even hallucination, would suggest any one of a great quantity of mental diseases. Some small tip or "hunch" would then suggest that the said symptom belonged in group X. Upon reference to books of authorities, said symptom would be unfailingly found in group X. A great number of collateral symptoms would also be found therein. To be sure, the systematist might have given some little idea of the statistical frequency of the given symptom; but he would be careful to say, for example, that a depression is occasionally found in dementia præcox and that auditory hallucinations are occasionally found in manic-depressive psychoses. The tyro bent upon making a diagnosis of one or other of these diseases would hardly get the statistical nuances of the entire situation.

Without going into this matter of the lack of indicator symptoms in the field of mental diseases, I think it will be conceded by all that a young diagnostician (or even an academic old one) is very often able to press the phenomena of practically any case into any one of half a dozen groups. Hence the obscurity and the delights of psychiatric diagnosis!

Where there are no indicator symptoms, it seems desirable to examine the entire logical material in an orderly way, confronting in sequence the various possibilities. This might be done by lot or in some other arbitrary fashion, as, for example, by an alphabetical method, or do it by a mere casting up of lots. For example, this method could be applied to the A. M.-P. A.'s classification as follows:

1. Is this a case of traumatic psychosis?
2. Is it a case of senile psychosis?
3. Is it a case of psychosis with cerebral arteriosclerosis?
4. Is it a case of general paresis?

5. Is it a case of psychosis with cerebral syphilis?
6. Is it a case of the psychosis of Huntington's chorea?
7. Is it a case of psychosis with brain tumor?
8. Is it a psychosis with other brain or nervous disease?
9. Is it a case of alcoholic psychosis?
10. Is it a case of psychosis due to drugs and other exogenous toxins?
11. Is it a case of psychosis with pellagra?
12. Is it a case of psychosis with other somatic disease?
13. Is it a case of manic-depressive psychosis?
14. Is it a case of involution melancholia?
15. Is it a case of dementia præcox?
16. Is it a case of paranoia or paranoic conditions?
17. Is it a case of epileptic psychosis?
18. Is it a case of psychoneurosis or neurosis?
19. Is it a case of psychosis with constitutional psychopathic inferiority?
20. Is it a case of psychosis with mental deficiency?
21. Is it a case of psychosis which we are unable to diagnosticate in any one of the previous 20 forms?
22. Is it a case which, on investigation and observation, gives no evidence of having had a psychosis and is, in the nomenclature of the A. M.-P. A.'s classification, "not insane"?

It is probable that the fatigue point would be reached early in this method of couching the questions of a diagnosis in sequence. It would in fact appear to the writer that the A. M.-P. A.'s grouping is a grouping based upon a deductive order derived from other considerations than those of diagnosis. The grouping is probably based upon certain notions of etiology. Psychoses with destruction of brain tissue appear to be placed early in the list, and psychoses in which the brains are normal or relatively normal are, with a few exceptions, placed late in the list. The order is one affected by numerous German text-books and is the opposite of what most French text-books affect. For the latter are apt to place their equivalents of manic-depressive psychoses, dementia præcox and the like at the outset of their discussions. Deductively, it would hardly matter which order one adopted in a reference book. For, having by some means obtained a diagnostic clue to the fact that a disease was probably alcoholic

or pellagrous or paranoic, one might then refer by index or table of contents to the reference book, in which would be given the differential signs for the disease in question. This would be the method adopted for general medicine in, for instance, Herbert French's "Index of Differential Diagnosis." It is in some sense the method adopted by Cabot in his "Differential Diagnosis."

It does not appear to the writer that this attempt at an etiological ordering has proved especially successful. It does not appear to him that either the German or French method can be said to be particularly superior to the other. It would, on the other hand, appear that a pragmatic ordering in the interests of diagnosis would be preferable to a theoretical ordering in the interests of etiology. To be sure, where etiology has been established and particularly where the morbid agent is single and definable, it is true that the theoretical and the pragmatic groupings would prove identical. But in how many mental diseases can we say that the etiology is established? In how many is it probable that a single morbid agent will be proved to be ample to bring the psychosis about?

In short, I feel that etiological classifications may have their place and that we are gradually approaching a unanimity in this most difficult matter. But from the standpoint of pragmatic diagnosis, that is to say, from the standpoint of choosing some therapeutic plan to follow in a given case, I think that the A. M.-P. A.'s order, to say nothing of the Kraepelinian order which it roughly follows, or any other ordering, *e. g.*, of French text-books, has little to recommend it from the standpoint of practical diagnosis. Shall any one say that we ought to begin to consider whether a psychosis is traumatic, senile, arteriosclerotic, before we consider that it is syphilitic, choreic, neoplastic, etc.?

However, the main objection to the A. M.-P. A.'s grouping, from the practical standpoint, is that the number of groups is too large to bear practically in mind, at least for the diagnostic tyro. It would seem desirable to throw these groups still further together, if we are not to transgress the fatigue point for the inexpert diagnostician. So far as the expert diagnostician goes, he truly may not require any special ordering at all, for the expert may on inspection catch up enough tips and "hunches" by which to arrive forthwith at something like the actual diagnosis. But

we are not here considering what the process type of diagnosis on the part of the expert is. We are, on the other hand, trying to choose an order in which to consider the entities of psychiatric nosology for the practical purpose of arriving at the entity whose choice will aid the patient as to treatment.

Da Costa used to remark that the process of diagnosis by exclusion was a tedious one. The remark appears to have been founded upon the idea that one might have to exclude all the nosological entities in the text-books one by one in order to arrive at a proper diagnosis by exclusion. Da Costa's text-book was one of the earliest of the modern single volume text-books in medicine that have so dominated medical schools and consulting room practice. The processes of diagnosis which the Philadelphia school and their followers have advocated and used, no doubt with great practical success, have been processes of clinical type-matching rather than processes of diagnosis by exclusion. I went into this matter somewhat *in extenso* in the paper called "*Diagnosis per Exclusionem in Ordine*," to which I will refer an interested reader. In point of fact, diagnosis by exclusion does not need to be tedious, if only the diagnostician is able to unite the different entities in his diagnostic field into a small number of groups characterized by particular signs and symptoms, or groups of such signs and symptoms.

How then might the diagnostician who should want to apply the logical principle of order in his diagnosis use such a classification as the A. M.-P. A.'s classification? Omitting to consider nomenclatural differences and thinking of the observational data in hand which he may desire to use, how shall the diagnostician proceed to choose one of the 22 groups of the A. M.-P. A.'s classification, or one of the 65 (more or less) clinical types mentioned under 11 of the 22 groups? (11 of the 22 groups of the A. M.-P. A.'s classification were subordinate clinical types; for example, group 4, "General Paresis," is not supplied with special clinical types to be used in general statistics, nor is group 5, entitled "Psychoses with Cerebral Syphilis," supplied with special clinical types, although the plural form "psychoses" indicates that there are probably several such types. Accordingly it would be safe to say that we deal with far more rather than far less than 65 clinical types in the A. M.-P. A.'s classification of mental diseases.)



How then might we order these groups and entities? I have proposed in the paper "A Key to the Practical Grouping of Mental Diseases" the following list, in what seems to me to be the most practical diagnostic order of consideration. (Let me here insist that this is *not an order suggested for the collection of data*, but an order for the consideration of all the data after they have been collected in due amount for diagnosis: any attempt to proceed to diagnosis before a due amount of data is in hand is bound to be dangerous or at all events of transitory value.)

#### MENTAL DISEASE GROUPS (ORDERS).

- I. Syphilitic ..... Syphilopsychoses.
- II. Feeble-minded ..... Hypophrenoses.
- III. Epileptic ..... Epileptoses.
- IV. Alcoholic, drug, poison ..... Pharmacopsychoses.
- V. Focal brain ("organic," arterio-sclerotic) ..... Encephalopsychoses.
- VI. Bodily disease ("symptomatic")... Somatopsychoses.
- VII. Senescent, senile ..... Geriopsychoses.
- VIII. Dementia præcox, paraphrenic..... Schizophrenoses.
- IX. Manic-depressive, cyclothymic..... Cyclothymoses.
- X. Hysteric, psych-, neurasthenic..... Psychoneuroses.
- XI. Psychopathic, paranoiac, *et al.*..... Psychopathoses.

As for group I, the Syphilopsychoses, it will be noted that, for practical purposes, I would wish to group the A. M.-P. A.'s groups 4—General Paresis, 5—Psychoses with Cerebral Syphilis, and 8—Psychoses with Tabes, together simply because in early phases of the development of syphilitic psychoses, a grave damage may be done to the patient if the diagnosis "general paresis" is affixed simply because the patient appears to have some features that correspond with the book authorities on early paresis. It seems to me that all experience indicates that no combination of clinical and laboratory signs will permit us to make a diagnosis between diseases of groups 4 and 5 without long study and the passage of years. Of course I would not mean to exclude numerous striking exceptions in which an immediate diagnosis of general paresis would be warrantable; but these striking exceptions of diagnosis virtually by inspection have nothing to do with the

stock difficulties of practical diagnosis. Here, then, is a good instance in which for practical purposes two or more of the groups and types of disease mentioned in the A. M.-P. A.'s classification might be fused into a single pragmatic group, having important signs or symptoms in common. I do not need here to argue further for placing Syphilopsychoses first in the list and will merely refer to the case book on "Neurosyphilis" which Solomon and the writer issued in 1917 along these general lines.

As for what I have called the Hypophrenoses, or in practice, the hypophrenias, let me here set at rest any question of nomenclature. (I have argued somewhat in detail for the value of the term hypophrenia in a brief paper called "Hypophrenia and Hypophrenics: Suggestions in the Nomenclature of the Feeble-mindednesses," which may shortly appear.) I would here lump the A. M.-P. A.'s group 20—Psychoses with Mental Deficiency, and 22e—the Not Insane, sub-group—Mental Deficiency without Psychosis, simply because the slightest evidence of any kind or degree of mental deficiency appears to me to have extraordinary importance. The plane of division between mental deficiency of a committable kind and mental deficiency of a non-committable kind is not a particularly important plane of distinction in the first task of diagnosis. Consider, for example, how little importance attaches to this matter in the field of delinquency, at least in our early confrontation of criminal phenomena.

Just as the Syphilopsychoses were placed first on account of the relative diagnostic reliability of the present-day tests, so the feeble-mindednesses are placed second, because of the relative reliability of modern mental tests and estimates of mental capacity, based upon observations of educability and functional capacity in schools or other standard environments. In practice hardly a case gets on nowadays without the performance of mental tests in all cases lucid enough to warrant them.

The Epileptic Psychoses correspond with the A. M.-P. A.'s group 17—Epileptic Psychoses, and 22—the Not Insane group of epilepsy without psychosis. Again the A. M.-P. A.'s distinction seems to be founded upon the question of committability and not upon the very possibly more important therapeutic lines of distinction. Epilepsy is placed early in this pragmatic ordering of groups, because in practice it appears to me that epilepsy is so

often forgotten and also because the clinical history of epilepsy or epileptoid states is often so relatively good compared with the clinical history of sundry other symptoms given us by lay witnesses.

Again, I have lumped in my pragmatic ordering the alcoholic, drug and poison psychoses, because the question as to their occurrence can be lodged practically in a single sentence. The A. M.-P. A.'s groups 9 and 10 roughly correspond with what I have termed the Pharmacopsychoses. (Nomenclature is not here in question, but it would appear that the Greek term in the first half of the word "Pharmacopsychoses" corresponds pretty exactly with both the alcohol and drugs involved in this group and the poisons there specified.)

The next fusion process in group V, which I have termed the Encephalopsychoses, may seem a good deal more questionable to the practical worker, but I consider that a group which takes into account those neurological signs which we think of under

A, signs of heightened intracranial pressure, and

B, signs of reflex asymmetry,

and the like, is a practical grouping. This group is in fact the neurologist's group. The technique of determining the focal brain lesion group of psychoses is the technique of determining the existence of focal brain lesions which are partly responsible for or are indicators of the cause of the mental symptoms, in a given case. I here lump the A. M.-P. A.'s group 1—Traumatic Psychoses, group 3—Psychoses with Cerebral Arteriosclerosis, group 6—Psychoses with Huntington's Chorea, group 7—Psychoses with Brain Tumor, and the larger part of group 8—Psychoses with other Brain or Nervous Disease (excluding Tabes).

It seems to me that the practical decision whether a case belongs in any one of these five A. M.-P. A.'s groups depends upon the neurologist's clinical technique and largely upon whether the neurologist can find signs of heightened intracranial pressure or signs of reflex disorder, asymmetry, and the like. It seems to me that the process of getting at the question whether such an encephalopsychosis is traumatic, arteriosclerotic, neoplastic, etc., is a question logically subsequent to the decision that the case belongs in the group as a whole. It may be inquired whether general paresis and cerebral syphilitic psychoses ought not to be

classified as Encephalopsychoses. It is true that from one etiological point of view, they might well be so classified; but we are not here attempting an etiological classification. We are trying to make a pragmatic classification that shall be of practical diagnostic and therapeutic value. There can be no question that from the standpoint of therapeutics, it is decidedly important to eliminate logically the question of syphilis before we come to deal with other forms of encephalic disease producing psychosis. The same principle of order in diagnosis may now be applied of course to the sub-groups or genera in the Encephalopsychoses, and some arguments in this direction have been given in the paper above mentioned "Genera in Certain Great Groups or Orders of Mental Disease." But to proceed to the more general ordering. Having gotten rid of the syphilitic mental diseases, the almost (in some form) omnipresent question of feeble-mindedness, the hardly less frequent question of some epileptic or epileptoid condition or equivalent, having disposed of the alcohol, drug and poison question, having applied the neurologist's technique and eliminated such matters as heightened intracranial pressure and reflex asymmetry, in what order shall we consider the remainder of psychiatric nosology?

Practically, I feel that the next question is that which the internist might best solve, and for this purpose I would group together, A. M.-P. A.'s group 12—Psychoses with other Somatic Disease, with its seven sub-groups, and group 11—Psychoses with Pellagra. I have given some arguments for the order in which these sub-heads under the Symptomatic Psychoses, group VI, might well be considered, in the paper above mentioned.

Having now put out of the way the internist's contribution, how shall we attack the numerically smaller, but logically more difficult residuum? Practically, I think at this point one should try to eliminate all the involutional, presenile, and senile questions. As for involution-melancholia itself, it is possibly of little moment whether it be classified under the presenile and senile group or under the manic-depressive group. We shall get the entity out in any event by our orderly approach. With some misgivings, I have, however, preferred to place the involution-melancholia group below with the Manic-Depressive Psychoses, leaving the other presenile psychoses to be grouped with the senile ones. It is of

special value in this method of attack that we have pulled so far apart the arteriosclerotic conditions from the senile ones.

We now approach the most difficult questions. I would practically place the schizophrenic question ahead of the cyclothymic question, because it seems to me that dementia præcox symptoms blanket manic-depressive symptoms from a diagnostic standpoint. Otherwise expressed, is it not in general true that practically any psychopath may show at times the characteristic mania or depression of the cyclothymic, but is it at all so true that characteristic dementia præcox symptoms appear in every form of mental disease? That schizophrenic symptoms do so appear, in the midst of, *e. g.*, manic-depressive psychosis, at least occasionally and as a rule singly, cannot be denied. But that any characteristic constellation of schizophrenic symptoms appears in any other disease than dementia præcox must be regarded as very doubtful.

Having then eliminated schizophrenia, that is, A. M.-P. A.'s group 15, and a part possibly of group 16, namely the part called "paranoic conditions" I would then proceed to the cyclothymic conditions which appear in the A. M.-P. A.'s classification as group 13—Manic Depressive Psychoses, and group 14—Involution Melancholia.

It seems to me that in practical discussion in early phases of mental disease, it is very salutary to fuse the question of Manic-Depressive Psychosis and Involution Melancholia, so that the diagnostic disputant might present to his audience all the phenomena that he thinks are cyclothymic at the outset.

We have now accounted for all the A. M.-P. A.'s groups except a portion of 16, 18, 19, and 21 and the larger part of 22. Having eliminated the cyclothymic states, I would proceed to eliminate the Psychoneuroses, group 18 of the A. M.-P. A.'s classification. Then, for my part, I cannot see any gospel for the orderly diagnosis of the remainder of the so-called entities, which appear to me to be of a very nondescript and variegated description. For example, paranoia seems to me not to have been proved to be of schizophrenic nature, and, although some forms of it appear to resemble chronic mania that some might press into the cyclothymic division, on the whole would it not be wiser to relegate paranoia to an extremely doubtful, special and unresolved group of conditions? As with 16—Paranoia, so with 19, the A. M.-P. A.'s group

of Psychoses with Constitutional Psychopathic Inferiority, this phrase means much and little. It has successfully borne an enormous weight in the matter of exclusion of certain immigrants. It is doubtless of great value in the matter of recruits. It is an ore for future psychiatric mining; but for my part I would not like to make the diagnosis until I had excluded all the previous ten great groups that I have just mentioned.

Of course, the undiagnosed psychoses, the A. M.-P. A.'s group 21, also belong in my chosen "ragbag" group 11, and there might appear 22d—Constitutional Psychopathic Inferiority without Psychosis, and 22f "others to be specified."

From the general results of this analysis, would it not be possible to say that the A. M.-P. A.'s classification, relatively successful as it is from the standpoint of a reference table for statistical purposes, and relatively successful as it may be in representing a reputable German etiological ordering, can be used with a certain readjustment in a practical orderly manner for the purpose of pragmatic diagnosis, having in mind special treatment and management as its aim? In short, may we not use this classification of the A. M.-P. A. like many others, by throwing its groups and subordinate clinical types into pragmatic groups arranged in key form, following the practical standards of, *e. g.*, Gray's "Botany"?

We thus arrive at the following general considerations concerning the recent American classifications in psychiatry:

1. There is an extraordinary unanimity on the part of American psychiatrists as to the constituents of psychiatric nosology and this despite a number of nomenclatural divergences.
2. The classification proposed by the American Medico-Psychological Association and adopted by the United States Government for practical war work is a suitable reference table for statistical purposes of the major groups and clinical types of mental disease.
3. The classification may be somewhat inadequate for the purpose of general and psychopathic hospital practice, but a slight revamping might resolve this difficulty.
4. The American Medico-Psychological Association's classification appears to follow an etiological ordering borrowed ultimately from reputable German sources, and this etiological ordering is a good one if a certain etiological viewpoint is in mind.

5. The question is raised, Whether it would not be better to order the groups and types of mental disease in a pragmatic rather than a theoretical order, that is, in an order having therapy in mind rather than an order having etiology in mind?

6. The writer proposes such a pragmatic order of certain great groups or orders of mental disease, corresponding with the botanical or zoological orders.

7. The writer finds that the 22 American Medico-Psychological Association's groups might well be compressed for practical purposes of diagnosis into 11 groups. He finds that the clinical types subordinated to the great groups of the American Medico-Psychological Association's classification correspond more or less accurately to the genera of a botanical or zoological classification, and proposes that in practice these sub-groups be considered in order, in general accordance with the principles of botanical or zoological taxonomies.

8. This question of how to use a classification may be defined as the question of a key to the grouping of diseases. The key question is entirely independent of the classification or reference-table of entities and entity groups, and both the key question and the classification-list question are independent of questions of nomenclature and terminology. Moreover, the writer would insist that the logical process of *diagnosis per exclusionem in ordine* here developed has nothing whatever to do with the order in which data can or should be collected.

#### DISCUSSION.

DR. ABBOT.—I was much interested in the subject of Dr. Southard's paper, and think he has given us many points of value. I agree with him that the names we use for mental diseases do not make so very much difference, provided we all understand the same thing by the same name. This nomenclature may be as good as any.

One criticism I would make: There are many new words of Greek etymology. Many of us have forgotten our Greek if we ever learned it at all, and it is rather hard to pick up a long name that does not convey any meaning to us. If his Greek could be converted into good English it would help popularize the scheme. As a sort of syllabus to help one to cover the ground and omit nothing, it is a pretty fair grouping.





## THE STUDY OF THE PERSONALITY IN PSYCHIATRIC CASES.

By GEORGE S. AMSDEN, M. D.,

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The conceptions covered by the term personality have been so varied and the connotations of this term are so multiform that it requires careful definition. By personality I shall here imply always a reference to adaptability. To get at once upon a ground of common understanding I would like to cite, with a minimum of detail, a case which brings into relief some of the issues I wish to offer for your consideration.

He is now 34 years old. Between the age of 15 and 29 he had 10 attacks of a mental disorder which closely resembled, but were not quite typical, of the manic depressive syndrome. His mood varied from frank elation to depression with attempts at suicide. He was mildly hallucinated and at times the symptoms were those of a mixed manic depressive psychosis. The attacks were all at their start associated with erotic excitement. He co-operated so well in his retrospective account and in the analysis that the circumstances of the onset of his attacks were worked out in rather minute detail. He had, it appeared, from the age of five a series of experiences which served to provoke and develop to a high pitch an interest or even a fascination for sexual matters. He attained in this connection imagination so vivid that he was capable of realistic visualizations. He was, however, in other respects an individual of excellent impulses. In fact, by the time he was 15, he had begun of his own initiative to wall off or circumscribe his unfortunate tendency. His attacks at length quite plainly appeared to be seasons of erotic debauches interspersed with periods of severe remorse. When he was 26, at the time of his first admission to the Bloomingdale Hospital, this feature of his case was utilized and he was given definite instruction in the management of this tendency. In other words, here was for this patient an opportunity, even a critical need, for dealing with a habit unlike an alcoholic or drug habit only in being infinitely more

subtle in its assertion and immeasurably more difficult in bringing about a denial of it. For his re-education his capacities for adaptation, that is, his personality, were very good outside of this particular field. He became accurately acquainted with his susceptibilities. He was taught how to strengthen his defences. The whole problem was one of steering an earnest desire to free himself from his disorder by developing in him a suitable adaptation. Following this attack he had two abortive attacks and one frankly severe attack and for the past five years has remained well. His adaptation, in part, consisted in a willingness to suffer the pain of his tendency in quite a frank manner as he would a tooth ache; in part also in a facility for learning to appreciate and deny the remote dangerous solicitations to the exercise of his unfortunate susceptibility and, also, in part to an ability to adopt a vocation adapted to his needs and to a facility for obtaining a sufficient satisfaction for a reasonably happy life in healthy ways.

Whether or not you are willing to entertain the possibility that, on a careful study of the case, it might prove that the way the case was handled was efficient in bringing about a remission of symptoms which have continued for more than five years— quite aside from this, the case serves my purpose in defining what I refer to as adaptation. This individual, quite capable of adapting himself to the external world, was balked, as so many of our patients are, when it came to an adjustment to demands arising from within himself and which pressed for satisfaction with all of the subtle strategy and cunning of racial instinct. There was, so far as I could observe, no factor of toxic or endocrine nature which was present or removed. Without submitting it for controversy on these points, I present it as illustrating an adaptation which scarcely any one may deny the value of and which in my experience is capable of broad utilization.

The utilization of this conception of adaptation in our cases, to be effective, must be guided by as precise knowledge of the adaptive possibilities of the individual as may be had. Much of the skepticism as to the value of re-education is probably due to discouragement experienced in trying to help patients without having first become accurately acquainted with their adaptive facilities. It is this study of the adaptive aptitudes of the individual which I wish to speak of.

The personality, in the sense in which it is conceived here, is in reality an index of the adaptability of the individual. For the personality is understood to be the aggregate of those personal habits, which, by continuous employment, have become so ingrained in the individual that those who know him can rather closely predict what course of action, what mental attitude, and what emotional responses he will display under given circumstances. The personality in this sense is, so to speak, the record the individual has carved for himself in his effort to win his way in the world. In quite an accurate way, therefore, an estimate of the personality may, also, be said to be an estimate of the adaptability of the individual. Certain correlations and interpretations must necessarily be made and these may, in part, be rendered clear by a concrete example of a simple and common type of pathological personality.

She entered the hospital at the age of 27. She was at that time very haughty and dictatorial. She kept aloof, spoke little spontaneously. On examination it was found that she heard voices. She spoke of communications from God and the angels. She thought her food was poisoned and misinterpreted the action of others and read into them meanings harmful to herself. She was always on the defensive and eventually became quite inaccessible and proved to be a case of paranoid dementia præcox.

She was of Jewish extraction but quite alienated from her race. There was nothing in her life previous to the age of 14 which need here especially occupy us. At 14 she became an actress and married at 16. From her marriage till she separated from her husband at 21 she was much abused by the latter and suffered severe hardships. She bore one child, still living at the time of her admission, and had numerous miscarriages. At 21 she contracted an alliance with a married man and from this time until her admission she became gradually more and more circumspect in her behavior, more and more particular and easily offended. Became haughty, changed servants and living places because of her suspiciousness.

Her personality was rather carefully studied out through the members of her family as informants. In doing this the effort was to get at her habitual reactions before they were modified by the unfortunate external influences of her life after she was 16. For

the purpose of establishing the level at which the individual is entitled to be estimated, it is perhaps best to start with obvious intellectual traits. In this case there appeared to be no deficiency on the side of intellectual acquisition. She learned readily. Her memory was good. On the side of application, however, it was noted that she was not practical, did not plan well, was changeable and not persistent of purpose. She was lazy minded. This is quite important as it forms one of a consistent group of traits which taken together serve to interpret her. It is in this connection noteworthy that while as a young child she was quite active and energetic physically, later on she was somewhat indolent and desultory in her activity. She was not inclined to talk and in other ways gave evidence of a lack of serious moving general interest. In the estimate of her relatives she was without ambition. She lacked aggressiveness and appeared to assume that things she desired and required would come to her in some way without planful effort. It could not be demonstrated in this case, as it is in most of this type of individual, that she day-dreamed or reveled in fancies. These foregoing traits, however, make it plain that she was deficient in her appreciation of reality. In some way it came about that the inevitableness of stern fact failed to reach her appreciation and she conducted her life as if the naive remodeling of reality according to her inclinations would work. It is suggestive, too, in the estimate of her, that she was without lively moving interest. Early in life she appeared spent both in interest and energy. The vigor which, in the normal child, leads to a manifold examination into its environment with that resulting experience which renders him eventually capable of coping adequately with the condition his environment imposes—that vigor in this patient appeared to be early neutralized or short-circuited.

Without trying to account for this, let me call attention to traits of personality which were evidently developed in relation to this deficiency which all such individuals come vaguely to appreciate in its effect. They universally feel different from others. This individual felt it. In reality she interpreted this as an inferiority. Perhaps the word interpretation implies too sharply conscious a realization and it would be better to say that she had a feeling of inferiority or self-depreciation. Her reaction, however, was the reverse of an humble one. On the contrary she was vain, proud,

self-conscious, felt herself above her family and made a show of independence and self-reliance. After a little careful study of the personality such an array of traits warrant us without hesitation to assume an original feeling of inferiority or self-depreciation which the traits plainly tend to compensate for.

In many individuals this does not fail to work out satisfactorily. This may be in a reasonably satisfactory way estimated by enquiring how well she managed herself in relation to other people. It was found that from childhood she was not sociable. She was distant, cold, and was unable to make friends readily. As a child she was disobedient. She insisted on having her way when it was not good for her. She would not receive advice or correction and could not be led to recognize her mistakes. She naively assumed that her wishes and opinions should pass without question. In these habits we see, in the first place, not only a shrinking from attempt at adaptation, but, what is worse, a group of habits or personal traits which tend to isolate her and remove her from opportunity for natural correction of error. The study of many cases convinces one that those traits are developed in relation to a vaguely felt deficiency. Such stubbornness and inaccessibility to personal contact with others are to be interpreted as habits developed with the rather pointed purpose of walling out inspection. These traits may therefore be regarded as evidence of habitual evasions of adaptation. The degree to which this process of steeling oneself against adjustment has gone in a harmful way may be estimated by ascertaining to what extent the individual has developed habits related to suspicion. In this case we find that she was secretive even as a young girl; that she blamed others for mistakes she herself made; that she was always on her guard to inspect the attitude of others toward her and was intolerant of anything which savored of criticism. She was not frank, did not have a facility for unburdening her trouble to others. Very many individuals of this type are over-conscientious, systematic to the point of being finicky and scrupulous to an excessive degree. These traits represent in the majority of instances automatic habitual tendencies to secure satisfaction from an assertion of painstaking in matters in which the individual's vital deficiencies are not revealed or brought into relief. In other words these traits represent an automatic and habitual tendency to seek compensation. The patient in question, however, was quite careless.

Traits of personality which may naturally be spoken of in connection with the spontaneous mood or moods of the individual throw important light upon his adaptability. The patient in question had little sense of humor, was serious minded, worried and brooded, was touchy and irritable especially with regard to any open or implied criticism. She had a sharp temper and was not forgiving. That is, we see here no reliance on herself or trust in the stability of circumstances.

Personal traits correlated with more definitely instinctive and habitual sexual attitudes were not, for lack of opportunity, adequately worked out. It is known that she was very fond of admiration, that she was quite erotic. She was habitually offended at any aggressiveness from others. Many individuals of this type appear mechanically to seek protection of a specious sort against a rather strong instinctive tendency by developing habits related to prudishness. They are apt to be over scrupulous in matters of morals, they turn away from sex matters with an affect of disgust or horror.

Finally the patient in question presented no traits indicative of an exercise of a healthy play or diversional instinct. Her interests were superficial. She had no compelling impulse to seek satisfaction outside of herself in self-assertion in any form. She had no hobbies—no ambitions. This is consistent with an absorption in emotional occupation in which the reference is entirely inward rather than to the world outside of her. Denial of the play instinct, moreover, requires strong competing interests and this denial in a degree measures them.

The patient, therefore, presents habitual reactions or personal traits which, on the one hand, indicate a serious ignoring or lack of appreciation of reality, and on the other hand, reaction or traits which appear to be developed with reference to a vague feeling of insecurity or inferiority and with the purpose of excluding sharp recognition of this inferiority both by herself and by others. These latter traits, such as stubbornness, those which favor shrinking from contact with possible corrective influence, result finally in an inaccessible isolation. She eventually broke down into a dementia præcox, of paranoid type, and has remained marooned there. Her adaptability is gone and she is rigidly fixed—embalmed within the swathings of unfortunate habits.

This is an extreme case. It requires no analysis of personality to reassure us that she is beyond help of any sort. From this shut-in type, there are infinite variations with, at the other extreme, a frank, open, wholesome personal makeup. Many of the instances constituting intermediate types do not lend themselves to an off-hand estimate in which all of the opportunities for re-educational approach are appreciated and rendered available. They require systematic study to bring out these opportunities.

Some years ago Dr. August Hoch and myself published a systematic guide<sup>1</sup> to such a study which I have followed in the case cited. Once the problem of the personality study is really grasped, the worker may prefer to formulate his own guide. It may be useful, however, to make some suggestions as to the serial order of topics upon which questions may be formulated. There are considerations also which relate to the informant questioned. The interview is naturally more profitable if the informant's interest is sustained and he should, so far as possible, be kept eager to contribute. The beginning of the interview is therefore best devoted to those things which the informant appreciates as important. Again to conserve his interest it is best to discuss topics with him rather than to go on the question and answer plan. The questionnaire plan is dangerous also because he may not understand the questions or give the same meanings to terms you do. It is well to keep in mind it is the informant's judgment you wish to obtain and often this cannot be adequately expressed directly by the informant, but requires some circumlocution which must be summarized by the physician. It will be well as far as is practicable and without tedium to approach certain topics from different angles so as to check up the informant as to accuracy. Of course leading questions are to be avoided. It is my habit to register an estimate of the informant in which his trustworthiness, his keenness, and the extent of his opportunity for knowledge of the patient are set down. With tact in handling the informant the interview is apt to arouse his curiosity and, exceptional cases aside, the co-operation is surprisingly satisfactory. It is well in taking a personality status always to keep in mind that it is the patient's adaptability which is sought and not a heaping up of mere information.

<sup>1</sup> Review of Neurology and Psychiatry, Vol. 12, 1913. Pp. 577-587. Also New York State Hospitals Bulletin, November, 1913.

A physician with a fair aptitude may in the course of a month or two become proficient in taking a personality status. After considerable experience it seems to me to work out best to devote a section of the anamnesis to this study and I find it best to take it after the anamnesis, since by that time the physician knows the informant and is also reasonably well oriented as to the important gross facts concerning the patient.

As was just stated the case cited represents one end of a series of personality types in which series the manic depressive type stands close to the opposite end. An example of this latter type is a woman of 43 when I studied her some 10 years ago. She was at that time early in her fourth attack. Her first attack occurred when she was 30. Each attack was a circular one and both manic and depressive phases were quite typical reactions and might serve as text-book examples.

Her personality is, in most respects, like her manic and depressive reactions, quite clear and transparent. Intellectually she is characterized as being keen minded, learning quickly and having a retentive memory. Quite in contrast with the preceding case she was practical, displayed good judgment in constructive affairs and planned with good foresight. Also in contrast with the preceding case she was active and energetic. She worked habitually under considerable tension so that she described herself as feeling as if she were wound up. She was similarly mentally active. This is indicated by a rather marked tendency to talkativeness. She was not unduly imaginative. In sharp contrast with the preceding case this one had a keen and in most ways an adequate appreciation of reality—if anything there was an over appreciation of it.

This case, though she accepted responsibility and successfully carried it, was nevertheless somewhat self-depreciatory. This she explicitly acknowledged. It was also implicitly seen in some of her reactions. For instance she worried readily, was unduly anxious, and rather over cautious. Unlike the preceding case she developed few other habitual defence reactions. She was somewhat proud, but not conceited. In her social relations it showed merely in not being as self-assertive as the general trend of her personality in an aggressive direction would lead one to expect. Otherwise she was socially quite apt, had many friends and enjoyed sociability.



In further contrast with the preceding case she was frank and open, freely recognized her mistakes and took advice well. She was not at all suspicious and was relatively free from such traits as jealousy. She was quick tempered, but quickly recovered from it and after it harbored no resentment. In her more instinctive habits she showed the same frankness and freedom from serious repression.

She was, however, in some way hopelessly committed emotionally and habitually so. Though practical, clear-headed and relatively free from the intrusion of her own interests in an unfortunate way ordinarily, her mood ran inseparably parallel to the trend of certain aspects of her personal affairs. She was a retail dealer in millinery. If she failed to make a sale her mood reflected it more than it ought to, but only for the moment. If she made a good sale she was comparatively elated, but also only for the moment. In matters pertaining to the welfare of her children this mood reaction was exaggeratedly responsive. Her attacks were coincident with similar emotional provocations at times when she was physically reduced. This fatalistic fascination of the mood with certain other aspects of experience is a type of behavior poorly correlated. In cases in which the personality is less fixed than it is in this one the value of training and re-education—particularly with regard to rendering more conscious the first steps of surrender so that the patient learns to recognize and heed danger signals—have been so frequently and fortunately demonstrated that they have become entitled to recognition as efficient aids in treatment. They must, however, be guided by a knowledge of the case such as only a careful systematic study of his habitual reactions may reveal.

Between the extremes illustrated—that in which the adaptation stands at a minimum and that at which the adjustment is quite good, except in one or two unfortunate particulars—there are naturally variations to correspond with almost any *a priori* conceivable sort. Certain common characteristics appear in the more common clinical types of mental disorder. The following case, a psychoneurosis with obsessions serves, in part, to illustrate this. He was 33 when admitted. He was a local officer in the federal government. Five years before admission he suddenly began to fear lest he cut his hand with glass. This extended to a fear of

anything with a sharp edge. This persisted continuously for two years. After this it was manifested slightly and occasionally until about three months before admission. During this period and some 18 months before admission he married. Analysis of the cases revealed the usual unfortunate habits of adolescence with certain homosexual inclinations.

The systematic study of the personal makeup showed that he was intellectually bright both in acquisition and in application. His judgment is said to have been good and he planned with good foresight. Nevertheless, there was in his judgment an automatic quality, observed in many of these cases, which allowed too little efficient pause between the conceived act or judgment and the carrying out of the act or acceptance of the judgment.

It is noteworthy that while he was rather energetic he was not inclined to talk much. He was, however, a good listener. This suggests a cautiousness which may have other manifestations in his reactions. It was found in corroboration of this that he is orderly to an excessive degree and that he is fussy about his personal appearance. Also his mood is not quite spontaneous. He is inclined to be serious, although he has a keen sense of humor. He is also very sensitive to anything which is readily interpreted as a criticism. Under stress, even of slight grade, he becomes anxious and is unable to wait an outcome with patience.

In his more naive behavior he reveals other characteristics of importance for treatment. He is free from unreasonable conceit and pride. He is mild tempered. He is not hypochondriacal. Within his light he is honest with himself and is free from undue imaginations. There is little formal evidence of self-depreciation either directly or by way of compensating habits, though he is slightly stubborn. He is not suspicious. He is easy to get along with and mixes socially without difficulty. Yet the study of his case rendered it plain that these traits do not in his case have the positive value of being coefficients of good adjustment by conscious effort or good training. They are rather in his case negative trait. He is in reality an individual of a type which naturally leans for support. He had not developed a complete well-rounded consciousness of self. He had not yet distinguished fully his own interests from those of others and of circumstances naturally closely associated with him. This juvenile quality was also ex-

pressed in his very simple attitude in personal relations. He is very affectionate, frankly jealous, particularly of his wife, very sympathetic and too open to emotional appeal by others. He trusts his friends implicitly. He has a simple religious faith. His recreations also remain free from adult complexity.

In such experience as I have had, cases of this general type have not as a rule become well suddenly, after an explanation which utilizes the behavioristic factors. They have rather required considerable retraining and often the guidance must be continued long after they leave the hospital. This case, which represents a somewhat extreme instance, was much benefited by treatment which consisted, in part, of explanation and in part also of a reorganization of his daily habits of life in such a way as to provide him with a steady flow of personal satisfaction.

The value of a systematic study of the personality for psychiatric purposes is only partly to be represented by the citation of single cases, for more of which I regret there is not now an opportunity. In purely administrative work, such as the classification of the patient in the hospital, the direction of his daily activity, his companionship and in forming plans suitable to his welfare after he leaves the hospital, it gives precision and efficiency. For the ready appreciation of the immediate needs of the case on admission, both as to precaution and prompt initiation of treatment, a good grasp of his personality is invaluable.

Moreover, a medical staff which is especially interested in, and tries to profit by, a study of the individual in all his aspects, is bound to be more efficient and humane, and the *esprit de corps* of such a staff will consequently be stimulating and progressive.

The value of a correct correlation of personal traits with adaptive facilities and difficulties in directing the education and development of children should itself stimulate a systematic study of personality in the rich material which comes to us. It is clear to me that, other circumstances being equal, a child which is very studious, which prefers to remain indoors and read rather than play with companions and is at the same time a model of goodness, is in need of careful assistance. On the other hand a child which is over-talkative, over-active, with tantrums and with enthusiasms which burn out readily, whose mood moves up or down with the light and shadow of its environment, is one to which proper direc-

tion is likely to prove invaluable. The sensitive, affectionate, socially delicate and dreamy child is perhaps of all the types most readily recognized as requiring assistance, but owing to general ignorance fails to get it. The child which least solicits our interest, but most needs it, is the stubborn, sensitive, willful child, lacking in frankness and difficult to get at.

Retrospectively these personality syndromes appear regularly in the childhood of patients who come to us. They are causally linked with unhappiness, inefficiency and disaster. Such correction of them as, later on, may be brought about in such individuals as patients, is accompanied by amelioration of their symptoms to an extent which justifies a place for the study of the personality as a part of the practical handling of mental and nervous disorders.

## TREATMENT IN NEUROSYPHILIS.

· BY BENJAMIN F. WILLIAMS, M. D., LINCOLN, NEBR.

The field of psychiatry, like medicine and surgery, holds within its official family, those who are intensive; and when psychomotor activity is directed in one line, it is but normal individual reaction to travel the full sweep of the cycle and with rhythmic precision reach a corresponding position in the reverse excursion.

Thus we must temper our enthusiasm by the soothing balm of retrospection, and estimate our results by the law of general averages.

The treatment of neurosyphilitic conditions by intraspinal method has received a counter thrust, and, as a result we are threatened with a reversal of methods in the disuse of proven treatment. This tendency should be checked in its backward swing.

While it is not within the scope of this paper to deal with therapy, I feel that some word should be said in defiance to the oft spoken diction, "Hopelessness of Neurosyphilis." I want to urge the prognosis in neurosyphilis is not more hopeless than chronic physical conditions in general, and to insist that it is our duty to approach the treatment of neurosyphilis with an open mind, free from bias, and with a confidence in our ability to so direct the defense, that the enemy will at least be held entrenched if not actually vanquished.

It has often been stated that differentiation between early paresis and early cerebrosyphilis might be accomplished through therapy, it having been established that early paresis could not be influenced by treatment.

Admitting the difficulty of distinguishing these conditions through interpretation of symptoms, one can hardly accept a dogma such as this, when reflection reveals no precedent in medicine so utterly destitute of the elements of deductive reasoning.

I prefer to regard syphilis wherever found, as presenting pathology varying in degree and location, much as parenchymatous and interstitial changes found in other parts of the body, and offering

relief from treatment in direct ratio to its accessibility and degree of advance.

Treatment of neurosyphilis is therefore treatment of syphilis and it is eminently important, if relief of nervous symptoms are to follow, that syphilis in the patient still be relieved.

It is not my purpose to consider hygienic treatment or symptomatic treatment, either of which are important and deserving of much more consideration than accorded by the average syphilologist; nor will I consider at length the therapy of the specific treatment directed to the destruction of the spirochæte, preferring to consider only intensive systematic intravenous treatment, with diarsenal, arsenobenzol and kindred arsenous preparations.

Two points I wish to emphasize:

1. The use of diarsenol and kindred arsenous products are of utmost importance in syphilis of all forms, and are not without value in syphilis of the nervous system.

2. Many failures in treatment of the nervous system are due to insufficient dosage and inconstancy.

I, therefore, justify this article in the hope of inducing my co-workers to adopt simple methods and feel that the simple method will invite more persistent effort.

For intravenous injection of diarsenol I employ the following equipment carefully sterilized:

- One vein needle.

- “ 4 oz. glass stopper bottle.

- “ 2 oz. medicine glass.

- “ 6 oz. normal salt (cold) sterile.

- “ 6 oz. distilled water (hot) sterile.

- “ 1 oz. 15 per cent sodium hydroxide solution sterile and fresh.

- “ medicine dropper.

- “ rubber tourniquet.

Two record syringe 20 c. c. or Leurs all glass syringe.

Rubber gloves should be worn and surgical cleanliness should be observed.

The contents of the diarsenol ampoule is placed in the glass-stoppered bottle and to this is added 20 c. c. of hot distilled water, vigorous shaking is required to dissolve the diarsenol which is facilitated by having placed some glass beads in the bottle.

When dissolved neutralize with sodium hydroxide solution, dropping one by one until solution is clear, after which 20 c. c. of cold normal salt solution are added.

While the solution and neutralization of the drug is being accomplished an assistant has prepared the field of puncture and applied the tourniquet well up on the arm.

Select one of the distended veins, preferably the median basilic, and with the needle directed toward the body and parallel with the axis of the vein, plunge the needle in until blood flows freely.

After freeing the tourniquet, the record syringe, having been filled by an assistant, is placed in position and the contents slowly and steadily injected. The vein should be constantly observed for evidence of distention, which clearly indicates too great speed in the process.

When the first syringe has been emptied, the second in the hands of the assistant is passed into position and its contents expelled, while the first syringe, having been cleansed in hot sterile water and filled with the remaining solution, is again placed into position and emptied, thus completing the process.

I want to emphasize as important:

1. Solution should be of body temperature as much pain is caused by injection of hot solution.
2. The adult dose should be liberal. I never use less than 0.6 of diarsenol, *adult dose*.
3. Chemically pure, freshly prepared sodium hydroxide only should be used to neutralize.
4. Concentrated solution—contrary to the accepted theory—has given much less reaction in my cases than the large volume with greater dilutions.
5. Cases of spinal and cerebrospinal syphilis endure as adult doses 0.6 gm. every week.
6. Mixed treatment KI internally and Hgcl 2 hypodermatically, should precede by 10 days the first dose of diarsenol and should be continued as a routine during the entire time of treatment as an adjunct to the diarsenol.
7. Large quantities of water should be given to patients while under treatment—sparkling carbonated mineral waters as Kalax, Appolinaris, and in addition drinking water in abundance.
8. Simplicity in technique will result in more persistent and vigorous effort, and relief to a greater number of early cases of syphilis of the nervous system.





## PELLAGRA AT THE CONNECTICUT HOSPITAL FOR THE INSANE.

By WILLIAM C. SANDY, M. D., MIDDLETOWN, CONN.,

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Pellagra has been found sporadically in most sections of the United States. It is this fact that has led one authority to assert that pellagra should not be considered a disease of the South, although so frequently observed in certain sections thereof, and that more cases would have been reported in other parts of the country had they not remained unrecognized. The rather widely scattered occurrence of pellagra, usually among the poorly nourished, may also help to establish the theory that faulty or improperly balanced diet is an important etiological factor. At least, it tends to the abandonment of the diseased corn theory of etiology. The infectious origin is still advocated by several eminent investigators who have sought to parallel the frequency of pellagra in Southern cotton mill villages with the absence of adequate sewage disposal facilities.

Much has been written upon the clinical side of the disease, and it has been shown that from a psychiatric aspect, pellagra is often associated with various psychoses, the effect frequently being to alter unfavorably the ultimate prognosis. It is not the intention at this time to enter into a detailed discussion of the various manifestations of pellagra. These are more or less familiar, especially to those connected with Southern institutions for the insane, and probably little if anything new could be added to the already extensive literature. During the latter half of 1917, however, there occurred at the Connecticut Hospital for the Insane at Middletown, five cases presenting clinical signs of pellagra. The rarity of the disease in this state and hospital, together with some atypical features has made these cases seem worthy of discussion.

According to a recent report, the first case of pellagra coming to the attention of the Connecticut Board of Health was a death

in New Canaan in 1911. Following this there have been reported several cases, in 1917 there having been six deaths from pellagra. The July, 1917, number of the Connecticut *Health Bulletin* contains the statement that pellagra "has been observed among negro tobacco laborers recently imported from the South." In the report already quoted, it is also stated that a former superintendent, for 30 years at the Connecticut Hospital for the Insane at Middletown, asserted that he had met with only one case, while at the Norwich State Hospital only two cases have been recognized.

In studying the histories of the cases under consideration, the type of the individual and the kind of psychosis are of some significance. It is quite apparent for instance, if one accepts the theory of faulty diet as the principal causal factor, that cases of dementia præcox or other psychoses in which there may be a tendency to take insufficient or improperly balanced nourishment, may prove to be likely subjects for the development of pellagra.

The first case, one of dementia præcox, paranoid form, after a hospital residence of over two years, presented the skin and mucous membrane signs of pellagra of a mild type, following persistent dietetic indiscretions. The physical signs of pellagra promptly disappeared when the patient was placed upon a rational diet, there still remaining, however, a few quite characteristic sequelæ.

CASE I.—No. 16814. Admitted January 6, 1915. A white female, born in New York, age 30, married, Protestant, housewife.

So far as ascertained, the family history was negative. Fourth in order of birth of five children, her early development is said to have been normal. She received a common school education, making good progress and later acted as saleslady until her marriage in August, 1917. In disposition, she is said to have been mild, steady and temperate.

Menstruation began at 12, with no abnormality. She had two still births and one living child born June 2, 1914. The psychosis developed rather suddenly, seven months prior to admission, a few days after the birth of her living child. She became restless, fearful and depressed. She claimed her people were sick, injured or in trouble and it was necessary for her to see some court official in order to have this matter attended to. She had auditory hallucinations, being annoyed by vulgar expressions. When admitted, she weighed 97½ pounds. She was anæmic, hæmoglobin 70 per cent, red cells 3,800,000, and a faint murmur in the pulmonic area (hæmic) was detected. She appeared confused and anxious, agitated by

her auditory hallucinations, hearing her brothers crying for help. Later on she became clear and well oriented. Memory appeared fair. She had no insight and judgment was defective.

Following admission, she has usually seemed aimless and has taken little interest in occupation. She frequently smiles to herself and has continued to hallucinate. Has expressed the idea that she was poisoned and had contracted a loathsome disease; also that she was Jesus Christ and was suffering for the sins of the world. Upon several occasions has visited her home for a few days or weeks at a time, showing affection for her child but irritability and dislike for her husband. Her physical condition improved in respect to the blood picture.

On April 19, 1917, it was noticed that the patient had bilateral and symmetrical lesions of the skin, involving principally the extensor and to some extent the flexor surfaces of the forearms and knees, there being also a few lesions on the neck. There was a region of slight ulceration on the tip and edges of the tongue. The whole symptom-complex was very suggestive of pellagra. Upon investigation, it was found that the patient, ever since admission, had been accustomed to an exclusive diet of bread and sweets, taking practically no meat, which she says she is unable to chew and does not like anyway. Every week her husband visits her, bringing fruit, candy and cakes, so that she had been eating very little in the dining room. She was placed upon a milk diet together with meat, eggs and other elements making up a well-balanced dietary. By July, 1917, she had improved in physical condition markedly and the eruption had entirely disappeared.

At the present time (March, 1918) there has been no recurrence of the skin lesion or other symptoms, but there is a roughness of the elbows often found in old cases of pellagra.

The second case, also one of dementia præcox, but hebephrenic form, after a hospital residence of about two years, during a part of which time she had to be tube-fed, developed the characteristic skin and mucous membrane appearances of pellagra. She was also tuberculous and finally died, the pellagra symptoms becoming more and more marked.

CASE 2.—No. 15574. Admitted September 15, 1915. Female, white, born in Connecticut, aged 31, married, Methodist, housewife. Information meager as to family history. Negative for nervous, mental and other important conditions so far as ascertained.

She was the youngest of four children, all girls, one of whom died from an unknown cause. At the age of seven, she is said to have had a head injury followed by a brief period of unconsciousness from which she made a satisfactory recovery. Aside from this, she is said to have been well during infancy, childhood and until present illness.

She made good progress at school, completing a grammar school and business college course, and for a time before her marriage, she worked as stenographer.

Her menstrual flow was always scanty. She married at the age of 23 and has had two children after normal pregnancies and labors. The younger child at time of admission of patient, was eight months old.

In disposition patient is said to have been sociable, mild but "nervous." She showed aptitude both for study and work. She was temperate and not a user of drugs. The psychosis was gradual in onset. The first symptoms appeared about three months following the birth of her second child which occurred in December, 1913. She seemed depressed, walked the floor at night until she became exhausted, and refused to eat much food. She expressed ideas of infidelity and called her husband vile names. She was a patient at a private hospital from March 22 to June 30, 1915, when she was removed by her husband against advice. While there she was resistive, refused food, would not answer questions, was untidy and once highly excited. She had to be tube fed and remained untidy until the last 10 days of her stay when she began to eat well, dressed and undressed herself, and entered into normal associations with others, conversing coherently. She did not develop insight.

Upon admission at C. H. I. Physically there was considerable emaciation; teeth in poor condition. Blood Wassermann negative. She was a little restless but entered into the hospital routine quite readily. She was evasive but expressed no well-defined delusions and there was no evidence of hallucinations. There appeared to be much emotional deterioration. Conversation was rambling. Memory was good. Her insight and judgment of the situation were defective. A mental diagnosis of dementia præcox, hebephrenic form, was made.

Following admission she was seclusive, showed a tendency to remain standing a great deal although weak, and was unoccupied. She lost much in weight and developed signs of pulmonary tuberculosis; after which she became very untidy, expectorating on floors and walls. Around July 1, 1917, she developed an erythematous condition involving the backs of the hands, fingers and wrists, extending about an inch and a half above the wrists. There were also red and roughened areas on both elbows and at the suprasternal notch, and an eczematous condition of the nose, forehead and lips. The tongue became red and inflamed.

Despite extra diet and other special attention, she continued to fail, losing in weight. Her breath became foul, she was salivated and she developed a characteristic odor of an advanced case of pellagra, from which disease she finally died on August 16, 1917. Permission for post-mortem examination could not be obtained.

The third case, one of dementia præcox, after some years of hospital residence in several institutions, developed pellagra symptoms. For several months prior to this she had persistently refused

food and was tube fed. She failed to respond to treatment, death occurring about a month after the appearance of the characteristic symptoms.

CASE 3.—No. 15632. Admitted November 16, 1915. Female, white, born in Pennsylvania, age 43, married. Congregationalist, housewife.

Father developed epilepsy after 40 years of age. Otherwise family history negative.

Early life and development not unusual. Graduated from Wellesley College and taught school until her marriage in 1900. Has had four children, three male, one female, the youngest being born June 20, 1908.

In disposition she was very sociable and sunny, not easily irritated. Never showed great capacity for work. She is said to have been rather eccentric and of a romantic nature. Following the birth of her last child in 1908, she neglected her household duties, wrote letters in which she prophesied many dangers and mysterious happenings. She did queer things such as endeavoring to have an acquaintance adopt her youngest child, taking her father from a private sanitarium to try to heal him herself, trying to exercise healing power on a strange child, burning her children's books and playthings, at times becoming excited, and violent if opposed. Received treatment in several private institutions and the Norwich State Hospital. She showed marked religious trends of a peculiar nature. On admission, weight 116 pounds, height 5 ft. 3 in. Poorly nourished. Sallow complexion. Wassermann negative. She entered readily into the hospital routine. After a while, at times performed peculiar acts such as undressing and going to bed directly after breakfast, which she said she did in obedience "to the spirit." She often talked to herself and reacted constantly to auditory hallucinations, being direct commands from God. Spoke of "wondermen of the world" through whom she communicated her ideas. General mental organization good. Insight and judgment defective.

Following admission she remained seclusive, neat and tidy, occupied in her room in embroidery. Constantly hallucinating, the false voices often directed her so that at times for long periods she would be absolutely mute, inactive, with eyes closed, holding herself in bed in a rigid position, refusing food and necessitating tube-feeding.

In December, 1917, she developed an erythema on the backs of her hands and wrists which was symmetrical, and which later became a dermatitis with ulcerations. There were also a symmetrical roughness of elbows, a seborrhœa of the face, salivation, a redness of the tongue and towards the end, diarrhœa. She became greatly emaciated. Although given special diet and other appropriate treatment she failed rapidly and died January 10, 1918. The eruption had become considerably less marked before her death, but the general symptomatology pointed to pellagra.

The fourth case was a colored woman, the diagnosis being dementia præcox. She had a positive blood Wassermann and had

been given a series of mercurial injections. One month following the last injection after which the Wassermann had become negative, and about five months after admission, the peculiar skin eruption and mucous membrane changes made their appearance. She also developed an intractable diarrhoea and died in about 10 days after the eruption was first noticed.

CASE 4.—No. 16514. Admitted June 4, 1917. Female, colored, born in Connecticut. Aged 42, single. Protestant, cook. Patient's mother, a white woman, is said to have been alcoholic and insane. Details as to her condition not ascertained. Patient is stated to have been result of intimate relations with negro hired man.

Infancy and childhood said to have been normal. She went to school from six to fourteen and made usual progress. Her occupation was that of cook.

In disposition she was shy and retiring. Details of her life otherwise meager.

Psychosis was of gradual onset during the past eight years. She developed the idea that she was white. She saw white faces as she looked in the mirror. At times, she would be noisy, excited, restless and talkative, at other times she would be dull and stupid. She put flour on her face and dressed fantastically as a young girl. Imagined her father was rich.

On admission she was well nourished. The only abnormality noted was exaggerated knee-jerks. The blood Wassermann was positive, the spinal fluid negative. Mentally, she was seclusive and reserved, neat and tidy in appearance. In discussing her peculiar notion about being white, she at times broke out in silly laughter. Spoke of wealth and social position. Would not cooperate in questions designed to test mental organization. Insight and judgment defective.

Following admission she remained seclusive, unoccupied and disinclined to talk or answer questions. In view of the positive blood Wassermann, she was given 13 mercurial injections, receiving a total of 23 grains of mercuric salicylate, the last injection being given on October 9, 1917. On October 29, 1917, the blood Wassermann was negative. In August she had a cough and some diarrhoea. At the time of her last injection she complained of sore mouth.

She continued as above, but gradually lost in weight. On November 20, it was noticed she had a peculiar roughness on the back of the hands with dark discoloration. This was accompanied by marked stomatitis and redness of tongue and oral mucous membrane. As noted above, she had not received any mercury for over a month. She was put to bed and given extra diet. She developed an intractable diarrhoea with fever, rapid heart action and a considerable cough. The sputum examination was negative. The odor of the stools became very offensive. The general symptomatology seemed to justify the diagnosis of pellagra. She died on November 30, 1917. Unable to secure permission for post-mortem examination.

The fifth case was a rather high-grade feeble-minded female with congenital absence of the palate and a positive blood Wassermann. Following a hospital residence of over five years, she developed the peculiar and symmetrical scaliness of the backs of the hands, associated with inflammation of the oral and genital mucous membranes and gastric disturbances. She had received mercurial injections, the last dose being given about two weeks before the development of the physical signs resembling pellagra. The skin and mucous membranes improved under treatment but the patient finally died a month later from cardiac degeneration. The patient appeared well nourished and there was considerable subcutaneous fat even at the time of death.

CASE 5. No. 14409. Admitted November 27, 1912. Female, white, born in Connecticut, age about 40, single, Roman Catholic, once worked in a corset shop.

Information meager as to family history. Negative so far as ascertained. Details of early life not obtainable. She stated that when she was about 12 years old, she had St. Vitus' dance which continued for several months. She had a common school education. In her earlier life, she worked for a while in a corset shop. For the 10 years prior to admission, she was an inmate of an almshouse. She was unmarried. Habits said to have been temperate. Onset of psychosis indefinite. There seems to have been no well-marked psychosis but perhaps rather a series of episodes. It is stated she showed "nervous" symptoms more so since the death of her stepmother some years back, after which she thought she ought to return to her father's house, but her father could not stand her actions. She is said to have "attempted suicide" by the introduction of a hair-pin in the bladder. She was excitable and attacked others in the almshouse.

On admission, she co-operated well in the hospital routine. Physically, there were found cleft palate, carious teeth with offensive breath, speech defect due to palate. Knee-jerks exaggerated. Blood Wassermann positive.

Mentally, she was quiet and well behaved, neat and cleanly in habits. She expressed no definite delusions except the idea that she may have been poisoned, and the presence of hallucinations was denied although she said she once saw her stepmother following her death. She was well oriented. Memory and general mental organization good. Judgment and insight defective. Following admission, she continued to be well behaved, but occasionally a little fault-finding. She assisted in the dining-room and later on in the sewing-room. Around the early part of December, 1917, she had been in bed upon several occasions and for several reasons. Some months before she was in bed for ill feelings accompanying the menstrual period. During this time, her pulse was found to be so irregular and

rapid that she was kept in bed as a matter of treatment. On account of a positive blood Wassermann, she had been receiving mercury hypodermatically, the last dose being given on November 30. She had an abscessed tooth, and it was extracted by a consulting dentist. About December 4, 1917, she had a severe vomiting spell, and she was again put to bed. It was reported that she had burns about the rectum which the patient explained had occurred sometime before as the result of the application (by her) of cotton saturated with oil of cloves given her by nurse for toothache. When she was placed in bed she was menstruating so an examination was deferred until the eighth, when it was found that there was considerable inflammation of the vagina and adjacent parts. Appropriate treatment was instituted by the woman physician.

There had also been a stomatitis and gingivitis, with marked redness of the tongue. After being in bed awhile, she developed a symmetrical scaliness of the backs of both hands. She had a continuous fever with very rapid pulse and complained of sore throat and vomiting. The latter became bile tinged. She appeared to be quite well nourished and is reported to have been a heavy eater. Notwithstanding this, the skin and mucous membrane appearance resembled somewhat pellagra, but the possible specific factor had to be borne in mind. Under treatment locally and special diet, the inflammatory condition of the mucous membranes cleared up to a considerable degree. She had much difficulty in retaining her food, however, and her heart action failed to respond well to treatment, there being apparently a marked myocardial degeneration. She gradually failed and died on January 4, 1918.

A post-mortem examination was performed of which the following is a summary:

*Hours post mortem.*—Forty-eight hours.

*Description.*—The subject is a female about 40, very well developed and well nourished. Skin white, soft and in good condition. There is a small abrasion over each knee and elbow, large brownish scales on the radial half of the dorsum of both hands, and roughening of the skin of the elbows. The hard palate is missing and there are only a few teeth, all in poor condition. On median section the fat is 2 cm. thick and the musculature is firm, dark red.

*Thorax.*—Costal cartilages cut easily. Mediastinum filled with yellow fat.

*Lungs.*—Each weighs 370 gm. The right lung is firmly adherent to the costal wall at all points except the apex. The left lung is free. There is no fluid in the pleural cavities. Both lungs float in water. There is some hypostatic congestion in both lungs. There is no evidence of tuberculosis.

*Heart.*—Weighs 230 gm. The pericardium contains the normal amount of fluid. The epicardium is very fatty. The heart is pale externally and on section the walls are thin, pale and contain many fibrous strands. There is no apparent valvular incompetence. The mitral valve has a small fresh vegetation on the anterior cusp and the endocardium below the valve is



opalescent. There is some atheroma of the aortic lining. The arch and descending aorta are only slightly atheromatous. Coronary arteries normal.

*Measurements.*—

Aortic .....	7.5 cm.
Pulmonary .....	7.5 cm.
Mitral .....	10. cm.
Tricuspid .....	
Left ventral .....	1. cm.
Right ventral .....	0.5 cm.

*Abdomen.*—There is a heavy layer of subperitoneal fat. The mesenteries are very fatty, and the fixed organs are embedded in fat. There is no fluid or evidence of inflammation in the peritoneal cavity.

*Liver.*—Appearance externally and on section normal. Weight 1100 gm.

*Kidneys.*—Weight 310 gm. The left kidney is large, soft, dark red and has two ureters which remain separate to the bladder. The capsule of both kidneys is somewhat adherent and the surface has a granular-like appearance. On section there is considerable increase of connective tissue. The markings are distinct.

*Spleen.*—Weighs 70 gm. Apparently normal.

*Uterus.*—There is a conical tumor about 1 cm. long projecting from posterior wall, which on section has the whorled structure of a fibroid, but is of the same color as the uterine wall. The endometrium is thickened and edematous. On pressure a considerable amount of glairy mucous exudes. The right tube is adherent to the pelvic wall and to the appendix.

*Brain.*—Weighs 1400 gm. Nothing abnormal noted.

*Anatomical Diagnosis.*—Adhesions from old pleuritis, endocarditis acuta, myocardial degeneration (fibrous), absence of palate (syphilitic), adhesions from right pelvic peritonitis, skin eruption suggestive of pellagra.

*Cause of Death.*—Myocarditis.

In studying these five cases collectively, there is found a rather striking similarity in several particulars. Four were cases of dementia præcox, having a peculiar type of personality with a resistive tendency and a disinclination to take nourishment properly. With a single exception, the pellagra symptoms developed after a hospital residence of two years or more, the exception being in a case of dementia præcox which had been in the hospital about five months. The latter and also the feeble-minded patient both had positive blood Wassermann and received mercurial treatment by injections, the pellagra symptoms becoming evident about a month after the last injection. Only one of the five patients responded readily to dietetic treatment with a favorable outcome. One of the cases of dementia præcox was further com-

plicated by pulmonary tuberculosis, undoubtedly an important factor in the fatal termination. Another was most persistent in her refusal of food, it being impossible to institute successfully a proper dietetic régime. In none of the cases did a diet of corn or residence in the South seem to bear any etiological relationship, nor was there obtained any evidence of other members of the family having been similarly affected.

The skin and mucous membrane symptoms did not make their appearance in any special time of year, one case developing in the spring, one in the summer, one in the fall and two in the winter. There had been apparently no previous attacks.

The lesions were symmetrical, there being an erythema of the backs of the hands extending in some cases above the wrists and later developing into a dermatitis with ulcerations. There were also gastric disturbances, seborrhœa about the nose, inflammation of the mucous membrane of the mouth and tongue with marked salivation and diarrhœa. In the two cases which had received mercurial injections, the salivation was at first attributed to the treatment, but with the onset of the symmetrical skin lesions of characteristic appearance, the whole picture seemed more that of pellagra.

The well-nourished condition of the last patient, there being a considerable amount of adipose tissue even at the time of death, is atypical but not unknown, especially in rapidly fatal cases, and there were complicating features such as a chronic myocarditis.

In every instance, the psychosis had been in existence for some years prior to the onset of the pellagra symptoms. The appearance of the latter seemed to mark the culmination of a gradual deterioration especially from a physical standpoint and might almost be spoken of as a terminal condition. In the præcox cases, as already stated, the psychosis may be considered an important etiological factor, the tendency to a faulty dietetic habit predisposing to malnutrition.

## THE WORK OF PSYCHIATRISTS IN MILITARY CAMPS.

By E. STANLEY ABBOT, MAJOR, M. R. C., U. S. A.

### INTRODUCTORY.

The primary work of the military camp is to make soldiers. To it are sent the young men of suitable age, after a more or less thorough sorting process. This first sieve is a rather coarse one, and many men get through who cannot be made into good soldiers, *i. e.*, men who cannot only fight, but endure the hardships, strains, and fatigue incident to modern warfare. The man who, barring wounds, cannot last through is a liability, not an asset, and must be eliminated.

Part of the medical work of the army is to eliminate these men while they are still in the training camps. This makes for a more efficient army, through its having fewer weaklings; it makes for economy for the government, through eliminating the cost of maintaining and training them in the first place, later the cost of taking care of them when they break down, and later still the cost of pensioning them; and, finally, it is more just to the men themselves by not subjecting them to strains which they cannot stand. Experts in various fields are called upon to make surveys of the men for this purpose—cardiovascular, tubercular, orthopedic, and neuropsychiatric.

Some men, though having defects—as flat feet, hernia, irritable heart, etc.—can be made into good soldiers. But the number of men with nervous or mental disease who can be made into serviceable soldiers is so small that in drawing a rough sketch of the work of psychiatrists these need not be considered.

In gatherings of men of the size of our military camps—from 20,000 to 40,000—it is inevitable that illness should arise. For the care of those who become sick there are not only the regimental infirmaries, but also the base hospitals. It is at the latter that the nervous and mental cases can best be cared for, and where part of the work of the psychiatrist lies.

Because the military camps exist to train men for fighting they must eliminate as rapidly as possible those who cannot be so trained. The army must keep its decks clear of incumbrances, of the inefficient. Hence, just as soon as it is determined that a man cannot make a good or enduring soldier, he is discharged. The medical department in these camps does not yet undertake the prolonged care or reconstruction of those citizens who come to camp with conditions which may need more or less prolonged care, unless there is a good chance that the man will eventually be made efficient as a soldier. That is civilian work at present. The attitude will be different, however, towards the men who have seen service, have given health or limbs to the cause, and have become invalided. These men will be cared for in the reconstruction hospitals or camps, presumably, for as long a time as they may need such care. If reconstruction departments shall be added to the base hospitals of the military camps, it is possible that the men who, on coming from civil life and before they have seen service, have chronic conditions needing long care and treatment, will be taken care of in the reconstruction department. Many reconstruction hospitals will be established quite independently of the military camps, however, for they need the proximity of industrial and educational facilities. But because of the advisability of continuing in them the military discipline and atmosphere, some will probably be established in connection with the base hospitals of the military camps, where that atmosphere is so prevalent. But it is doubtful if even then wards will be established for more than emergency work for the strictly psychiatric cases, as it will probably be found that special hospitals for these cases or the civil hospitals for the insane already established can take care of them more adequately. In saying this I am expressing only my own personal opinion and not any official judgment or plans.

## I.

In the military camps, as distinguished from the reconstruction camps that may be established, the work of the psychiatrists falls into four main types, of which two are in the line, and two at the base hospital.

1. *Educative*.—This war has brought about many innovations, and among them is a consideration of the individuality and of

the mental and nervous condition of the prospective soldier. But the line officer does not always appreciate this nor know what things to be on the lookout for in order to detect the indications of such abnormal conditions in the men as may be detrimental to the service. So a part of the work of the psychiatrist is to give talks to the line officers, telling them how the various mental and nervous conditions interfere with the making or the dependability, or the endurance or the efficiency of the soldier, and what types of behavior he should be on the lookout for. Their cooperation in looking for these conditions and sending men for examination or observation is asked for. Some are very much interested and cooperate, others think it all nonsense, others are indifferent. Such talks have to be arranged for with the regimental commanders. If one wishes to talk to the medical officers only, the arrangements are made with the division surgeon. But it is advisable to talk to the non-medical officers as well, and even to the non-commissioned officers, for they see much more of the men than the medical officers do. Such educative propaganda will have its far-reaching effects in civil life after the war is over, and I regard it as a very valuable opportunity to spread such suggestions in the community as that there are great individual differences in men and that the law-breaker, for example, may be a mental defective who needs different treatment from that of a non-defective, and other more advanced ideas relating to the non-efficient class.

2. *Survey*.—An important work of the psychiatrist is to make a survey of the whole personnel of the camp. The ideal way to do this would be to have the recruits on arrival at camp come into special barracks where they could be held before being assigned to any organizations until the various special examiners could go over them at reasonable leisure. An approximation to this plan is made by having the recruits very hastily surveyed by the examiners as fast as they come in. The men are stripped and run the gauntlet of the various specialists. The examinations must be very superficial when over 1500 men are looked over in a day. Many slip through with defects which are detected some time later who would have been eliminated in the first place if only half the number were examined in the same period of time. Four neuropsychiatrists have been able to make

a superficial examination as fast as the other examiners were making theirs.

Before even this plan was adopted, and wherever it has not yet been put into practice, a survey of the personnel, regiment by regiment, is made when possible. It is necessary to secure the cooperation of the commanding officer of the regiment for this. It is sometimes easily secured, sometimes he resents it as an interference with his work of training soldiers because it takes the men away from their work. Whenever possible it is advisable to make the survey in cooperation with the tubercular or other examiners, for example, as it causes much less loss of the soldiers' time. After the commanding officer gives his cooperation, arrangements are made with the regimental surgeon and the adjutant to have the men of a given company remain in barracks or report at the regimental infirmary at a given time. There the psychiatric examiners go over each man, testing pupillary and tendon reflexes, coordination and station, looking for tremors and for scars suggestive of epilepsy, and asking a few questions as to heredity, environment, schooling, convulsions, or nervous break-downs, meanwhile noticing any peculiarities. Under the most favorable conditions, with a roster of the company, and a clerk to check off the names and put down findings, one examiner can make a fairly thorough preliminary survey of from 150 to 200 men a day, according to their quality. But in actual practice that number cannot be examined on an average, because of time lost in going from one organization to another, changes in daily orders in the organization, misunderstandings, etc. It was found at Camp Sherman that making allowances for Sundays, holidays and unexpected interruption, interferences, and delays, one examiner could be counted on to go over about 2800 to 3000 men a month. The time available and the size of the command will determine the number of examiners needed to complete a survey in a given time.

This type of survey is unsatisfactory for it can never be complete. Men are transferred out from a company that has been examined and men from unexamined units are often put in to fill up the organization, and it is difficult for the examiners to go back and pick up these men.

3. *Observation and Diagnosis.*—In such survey there is not time to make thorough examinations, and some cases need continuous observation. All cases that cannot be decided on at the preliminary survey are referred to the base hospital, either to be admitted as patients for observation or to be examined thoroughly at greater leisure. The psychiatrist at the base hospital sees these men, makes careful examinations, often spending an hour or two at a time on one patient, applying Binet or other tests where needed. He writes for information to relatives, employers, or attending physicians; or gets information as to the man's behavior from commissioned or non-commissioned officers or privates, with a view to getting such data as may help in the diagnosis of epilepsy, mental deficiency, peculiarities, malingering, etc. It has been found very helpful to have a non-commissioned officer go to the patient's company to make inquiries about his general adaptive reactions or about some special incidents.

Besides the cases thus referred by the surveying examiners, there are sent over to the base hospital by the line officers patients in whom they suspect evidences of nervous or mental disease. In the camps where psychological surveys have been made, the psychologists have also referred cases to the psychiatrists. These cases are examined in the same way as those sent by the psychiatric surveyors.

In addition to these many cases are seen in consultation in the other wards of the base hospital. Many of these are neurasthenics, in whom the question of malingering arises. Sometimes the advisability of operating on a given patient comes up, as, for example, in a case of hernia in a defective. If he is too deficient mentally to make a good soldier, operation is advised against.

Another group of cases that comes before the psychiatrist is that of the men who have been arrested for various offences—stealing, desertion, repeated absence without leave, etc.—in order to determine their responsibility for their acts, and whether or not they should be brought to trial by court martial. In one case that recently occurred a man had already been convicted for refusal to be operated on for hernia. Before sentence was passed, however, the question of his mental ability was raised,

and it was found that he was about nine years old developmentally. He was not sentenced, but discharged from the army.

4. *Treatment*.—The cases of mental disease arising among the men, such as manic or depressive states, dementia præcox, acute alcoholism, delirium tremens, etc., have to be taken care of and treated until some adequate disposition can be made of them. It falls, of course, to the psychiatrist to exercise the care of these, as well as of the cases sent for observation or special examination. The psychiatrist has to determine whether the patient should be allowed to go home, or should be sent to an institution for the care of the insane; also, whether he can be allowed to go home alone or must be accompanied by one or more persons. And if the patient goes to a hospital, the psychiatrist should prepare and send adequate records of the case.

5. *Discharge*.—Since the vast majority of the men who are found to have some nervous or mental disease or defect are incapable of making good soldiers or of enduring without breaking down the stresses of warfare, they have to be discharged. It is part of the work of the psychiatrist to make the recommendations for discharge, giving the diagnosis, and stating how the condition interferes with the man's performing general military service. In some camps the psychiatrist makes his recommendation to a general disability board, of which he may or may not be a member. At Camp Sherman three of the psychiatrists themselves constituted a disability board. This gave an opportunity to hold conferences over the cases, to which the other neuropsychiatric examiners and sometimes other physicians were invited.

The judgment as to whether a case should be discharged or retained in the service has often been a puzzling one to make. The decision would be easier if there were no border-line cases. Two recent policies have served to help greatly in this matter. On April 2, 1918, an order from the adjutant general directed that border-line cases (in any field) will not be discharged, but that their service records will be endorsed "fit for domestic service only." And the surgeon general wrote on May 11, 1918, that it was the opinion of that office that there were no border-line cases in neuropsychiatry, with the exception of certain cases of mental deficiency and drug addicts. Thus many of the slighter



degrees of neurasthenia and psychoneurosis, which were puzzling before, are now clearly dischargeable; and many mental defectives, capable of simple work under direction, but incapable of general military service, can be retained who before had to be discharged.

## II.

Some of the kinds of cases and of difficulties that confront the psychiatrist can be illustrated by our experience at Camp Sherman.

The feeble-minded make up the largest single group of cases. Up to May 1, 134 out of 468 cases recommended for discharge were of this group. Before the order of April 2 was issued, it had been our custom to recommend the discharge of those who measured below ten years. Since then we have recommended the retention "for domestic service only" of two men who would have been wholly unfit for general military service. They measured between nine and ten years intellectual development, but were strong and healthy, industrious, willing, good-natured, orderly, with no asocial or antisocial tendencies, and had some sense of responsibility. They had been at work in the quartermaster's department for six months or more, one sweeping out warehouses, helping load trucks, etc., the other keeping latrines clean and looking after a small boiler for heating water. Their work was satisfactory, and they were only sent up for examination because the examiners in making their survey recognized their mental deficiency.

On the other hand, a man measuring about 13 was forgetful, had so little sense of responsibility that he could not be depended upon to carry out orders, went off without leave, and was not cleanly. He was unsuited even for stable work or general labor, so his discharge was recommended.

Those measuring 12 years old and over were regarded as suitable material for the army unless they were of unstable make-up, had shown economic or social inadaptabilities, or had some general physical disability, even though the latter were not sufficient in itself to be a cause for rejection.

At Camp Sherman the epileptics formed the next largest single diagnostic group. If the epileptics and organic nervous diseases are grouped together, this whole group is a trifle larger than that of the feeble-minded. Most of the patients could give a char-

acteristic description of the onset of attacks, but in two there seemed to be absolute amnesia for them, and for having had them. One had a typical grand mal seizure, seen and described by a young physician; the other made a suicidal attempt in barracks and later in the hospital; no recollection whatever of either attempt could be elicited either by ordinary questioning nor when hypnotism was attempted. No other cause for the suicidal attempt could be unearthed than a probable epileptic crepuscular condition.

Among the officers referred for examination, manic-depressive depressions predominated, and these were the most frequent of the actual psychoses seen at Camp Sherman. Of my own personal cases, 22 out of 30 psychoses were manic-depressive cases. There were only four cases of dementia præcox in this personal series.

There were many cases of neurasthenia following trauma or severe illness, and it was often a difficult matter to determine whether it was a real or an assumed disability. These cases were usually kept under observation several weeks, and information was sought from physicians who had attended them in civil life. Consultation with the orthopædists or other specialists was frequently held. X-ray examinations were usually negative, as were the results of spinal puncture and Wassermann tests. There were other types of neurasthenia, some with a number of vagotonic or hyperthyroid symptoms, without thyroid enlargement. These were recommended for discharge on the ground that they were not capable of standing the strain of general military service, nor even of domestic service. By searching inquiry one can elicit from almost all men an occasional neurasthenic or fatigue symptom. But of the 388 men whom I personally examined carefully only 29 showed enough symptoms to make it evident that they could not endure.

When a large number of drafted men are received there are always a few cases of alcoholism, delirium tremens, and drug addiction. The confirmed habitués could not be kept in the base hospital long enough to be reconstructed, and once they were in the ranks they could comparatively easily get the drug. One told me that previously, when in the base hospital, he had been able to get it, even there.

There were not many constitutional psychopaths (35 in all), but a few, sexual perverts, paranoid personalities, and inadequate personalities, were found and recommended for discharge.

The cases examined with reference to whether they should be brought to trial or not were principally for repeated absences without leave, or for desertion. One case was for forgery, another for stealing, and one, dementia præcox case, for refusing to obey orders. Some were clearly feeble-minded, and proceedings against them were stopped and the men were discharged. Two measured between 12 and 13 years, but had good understanding of what they were doing—desertion in the one case, stealing in the other—and were allowed to stand trial. Another, measuring 14 or 15 years, had a long insane hospital and penitentiary record, and was also regarded as being sufficiently developed to stand trial for forgery. The decision in these cases has to be made with different conditions in mind from those which obtain in civil life. There is no indeterminate sentence or probation. It is either full acquittal and return to the ranks, or sentence to the military prison at Fort Leavenworth.

A number of cases of persistent enuresis were under observation. Most of these were mental defectives, with rather small bladder capacity (280 to 350 c. c.). One was a very intelligent fellow whose father corroborated all the essentials in his claims of never having been able to control his bladder while asleep. He, like the others, was discharged,

The following summary of the work done at Camp Sherman up to May 1, 1918, may be of interest:

Examined in general survey .....	25,025
Drafted men .....	7,399
	<hr/>
Total .....	32,424
Cases with positive findings:	
Nervous diseases including epilepsy .....	137
Psychoneuroses .....	91
Psychoses .....	91
Inebriety, including alcohol and drugs .....	17
Mental deficiency .....	134
Constitutional psychopathic states .....	35
	<hr/>
Total .....	505
Recommended for discharge .....	468

## DISCUSSION.

DR. PIERSON.—I have listened to the paper of Dr. Abbot, and he has emphasized two very important points: One is that it becomes necessary to educate the line officer; the next thing is that the army matters are conducted by commission—everything is commissioned. That recalls to my mind the absolute necessities of medical recognition, because routine medicine has not been recognized in the organization of army affairs. It strikes me that the medical men ought to do something to increase the rank for commissioned officers, as efforts have been made in other directions. I do not know of any effort, I might say, that could be made that would be more useful than the endorsement of the Dyer and Owen bill, which gives greater rank to the medical men. I think this association ought to go on record as endorsing the Dyer and Owen bill to give us a proper rank in the medical forces.

DR. BURR.—Dr. Hulbert at the Great Lakes Naval Training Station told us yesterday that, contrary to the experience of the cantonments, he has found that there is a larger percentage of manic-depressives. Those at the Great Lakes Training Station are enlisted men, whereas in the cantonments the men belong to the National Army; there they get a larger percentage of dementia præcox.

DR. WOODSON.—We have received eight persons from the various cantonments, and out of those eight, three have been manic-depressive cases and one dementia præcox; one of the cases had received anti-meningitic serum; he was acutely disturbed with marked elevation of temperature.

## FOOD, SERVICE AND CONSERVATION IN A PROVINCIAL HOSPITAL.

By J. C. MITCHELL, M.D.,

*Superintendent Hospital for Insane, Brockville, Ont.*

The problem of satisfying the hunger of the inmates of a provincial or state hospital at a moderate expense, and with a menu nutritive, varied and palatable, cannot be overestimated. Since the prices of all food products have advanced to such a height during the past two years (owing to the demands made on us by the great war for freedom in which we are all so zealously engaged), this question has become a very vital one.

During the past seven years those having to do with this question in our hospital, have made a greater effort than ever before to vary the monotony of the meals. "Variety is the spice of life," and this is notably so in feeding the large number we have in our various hospitals. A large number of our patients are so advanced in dementia that the quality or kind of food does not appear to make much difference to them. Many of them are gluttonous and will eat not only the portion allotted to them but that belonging to their neighbors if they can lay hands on it.

"Ne'er looks to heaven amidst his gorgeous feast,  
But with besotted base ingratitude  
Crams, and blasphemes his feeder."

We always have, however, a large number to whom the kind and quality of foods is very essential. We all notice in going through our wards, when we have some special change in the quality of the meal, how pleased the better class of patients are. A good and satisfying meal that appeals to them makes such a difference in their attitude, they are so much better natured, so much kinder with each other than they are when they have a meal that is insufficient, poor in quality or served in such a way that it arouses a feeling of resentment. Food, no matter how plain in quality if well cooked, seasoned, and properly served appeals to our senses in such a way that it makes a great difference to our daily lives. It must be ample in quantity and bulk, and served with fruit and

vegetables. If properly cooked and tastefully served it becomes a very valuable therapeutic agent in our type of hospitals—patients are so much more accessible and respond so much better to treatment.

As carefully as we have looked into this subject, and as much time and thought as we have given to its consideration, we are not able to satisfy ourselves that we are doing the best we can for our patients.

For many years the diet in our hospital was extremely monotonous. Breakfast consisted of porridge, bread and butter and tea. Dinner—boiled beef (with the exception of Friday when fish was furnished for most of the patients), potatoes, one or more vegetables and boiled rice or a pudding. Supper—bread, butter and tea with stewed figs, prunes or syrup and cheese on Sunday evening. On Thanksgiving Day we served pork, and on Christmas Day fowl and an elaborate dinner, and plenty of eggs for all at Easter. These were about all the changes given during the year. In 1911 this diet was varied a good deal by furnishing an occasional soup, and pork in some form for dinner once a week. We raised our own pigs, and our fat cattle were purchased for us, and they were butchered and prepared at our own institution. Fish for Friday was so difficult to procure fresh in summer that we began the use of canned salmon. This we found worked so well that we have kept it up ever since. We have found it to be cheaper and more palatable and we serve it in different ways—occasionally cold but usually heated and served with white sauce.

In 1914 our Department (the provincial secretary's) in the Ontario Government instituted a plan to be followed in all our hospitals by which we were to adhere to the basic dietary ration table, as prepared for the New York state hospitals. The plan issued to us embraced not only the patients but the officers and employees. We still follow this ration table but have made some changes as we found the bread was not sufficient to satisfy our people. We issue to patients a daily bread ration of 14 to 15 ounces, meat 4 ounces, beans  $1\frac{1}{2}$  ounces, butter  $1\frac{1}{4}$  ounces, rolled oats 1 ounce, sugar  $1\frac{1}{2}$  ounces, cheese  $1\frac{1}{4}$  ounces, tea  $\frac{1}{2}$  ounce and potatoes 7 ounces. We find this ration works out very satisfactorily. We have a large blackboard, placed in a prominent part of the central kitchen, which gives at a glance the number of

patients in residence. The census is altered on the 7th, 14th, and 21st, and last days of each month.

We also inaugurated a system for looking after the waste. All the wards return to the kitchen, after each meal, the usable and unusable food. This is weighed carefully and a strict account kept, and the usable food (except the unused cooked cereals which are added to the soups) are returned to the wards from which they came, to be again made use of, and the unusable food going to the garbage. We find this weighing of waste of great benefit to us financially as there is not nearly so much garbage as formerly. The garbage is removed to the piggery, where it is thoroughly steamed and made use of for consumption in that department.

We have a large farm in connection with the hospital that is situated two miles from the institution. We have there 30 resident patients (5 females and 25 males) and 13 of a staff. This staff consists of the husband and wife as supervisors in that department, and the balance consisting of employees who are engaged in farm work. We do not have the waste returned from there, but it is very carefully looked after and properly made use of. The population of the farm is exactly under the same ration standard as the other parts of the hospital, with the exception that owing to an increased demand for food on the part of those working in the open air there, the patients are given a larger amount of meat daily than we give at the main building.

During the year 1917 we had a Dominion Food Controller (Hon. W. J. Hanna) appointed, and we made some changes in order to conform with his regulations. At present our menu for patients is about as follows: Breakfast—cereal, either oat or corn meal, tea, bread and butter and an egg to those requiring extra diet. On Sundays we serve coffee instead of tea. Dinner on Sundays—headcheese, bologna sausage, or provincial ham with potatoes, vegetables, rice pudding and tea. On Mondays, Wednesdays and Thursdays either an Irish or brown stew well provided with vegetables, also potatoes with bread and butter and tea and a rice or bread pudding as dessert. On Tuesdays we serve soup made of stock (from left-over bones, meat trimmings, etc.), beans (with a little pork), vegetables and a dessert. On Fridays, bean or pea soup (which is rich in proteins), with canned salmon, the usual vegetables, and pickled red cabbage or sauerkraut. On

Saturday a boiled meat with the usual accompaniments. The suppers are bread, butter and tea with cheese on Sunday nights, and during the week, one night creamed carrots and peas, another boiled onions with creamed sauce, marmalade, and a third night with macaroni and cheese. The other evenings syrup or sauce is served, and sauerkraut with some evening meals. Of course at all meals green vegetables such as lettuce, etc., are served when available.

The menu on Sundays for the staff for breakfast is: Either corn flakes or shredded wheat; Mondays, Wednesdays, Thursdays and Saturdays—a cereal, toast, sauce or marmalade, and either tea or coffee. Tuesdays and Fridays—(meatless days) eggs are served for breakfast. Dinners (four days a week)—roast meat with potatoes and vegetables; vegetable stew on Tuesday, and on Friday fresh fish. On Sundays and Tuesdays as dessert we serve ice cream (skimmed milk) or a water ice; various desserts are served up on the other days. Saturdays they frequently have sausage and sauerkraut. Supper for the staff consists of cold meat with potatoes for five nights in the week usually with pickles or a salad, bread, butter, and tea, and the other nights cheese or baked beans.

The officers' table differs very little from that of the rest of the staff with the exception of fresh fruit in season, and when available poultry or some change of meat on Sundays.

On Fridays we use for the patients 130 cans of salmon and when meat is used from 140 to 175 pounds. This year we had such a large quantity of cabbage that we put down five tons of sauerkraut. The amount of meat, either bologna or headcheese, used on Sundays is about 160 pounds. This is prepared at our provincial abattoir, Guelph, from which all our meats have been shipped since 1915.

We might mention that we grow a very large quantity of strawberries, sufficient to feed our patients a number of times during the season. The same may be said of asparagus. Tomatoes and fall apples are usually a heavy crop. From the time they first come in until late in the fall our patients are furnished with all they care to eat (both raw and cooked); they are perishable products so they consume a great many of both these articles. In the spring of the year we always procure a large quantity of maple syrup at a reasonable price which is a great treat for all.



With the increased price of food products we find it more difficult to serve a good evening meal and our experience has been that apples at even \$5.00 or \$6.00 a barrel are cheaper than nearly anything else we can provide so that this last winter we have served a good deal of apple sauce for supper. They are usually prepared by boiling the apples whole and putting them through an electric pulper which extracts the skin and core. This, sweetened, is very palatable. Occasionally we have served baked apples to all. In order to prevent this becoming monotonous we have also used prunes, evaporated peaches, and as mentioned in our menu, macaroni with white sauce made from skimmed milk.

We have three special diet kitchens, one in the male admission ward and two in the female admission wards, one being in the new Reception Hospital. From these places food is prepared and served to the patients, independent of the main kitchen. The food served here is that ordered by the physicians in charge for the newly admitted patients, and for those who are ill, and require special care and diet; the main kitchen of course being entirely under the chef. We have no special dietitian as is provided in a good many hospitals but our storekeeper has charge of all food supplies and issues the amount of special diet to those preparing them in the different locations. The nurses who are in their intermediate year have charge of these diet kitchens and they are on duty there for two months. In this way all nurses get an education in preparing diets and we find that this plan works out well.

We have a dining-room in connection with each ward. The largest number we have in any one room is 70 patients. Our dining-rooms are well lighted, bright and cheerful and the rooms are kept in excellent repair; the walls painted a light color and everything done to make these rooms as tasty as possible. We have small tables that accommodate about eight so we can group congenial people together. We have a special warming closet in each dining-room so that in cold weather we always have hot plates ready for use.

Our gardener takes a great interest in our wards and dining-rooms and all our tables the greater part of the year are furnished either with plants or bouquets. During this past winter there has not been a single day but what our wards have been well supplied with plants or flowers. This adds very much to the attractiveness of the rooms.

Patients' meals are served at 6.30 a. m., 11.30 a. m., and 5.30 p. m. We have meals at these hours so as not to conflict with the meal hours of the nurses and attendants. All the nurses and attendants are on duty at meal time and are expected to give their services exclusively to seeing that the patients have proper attention.

In the admission and hospital wards there are a great many trays to be served to those who are confined to bed. Everything possible is done to see that our patients get their allowance of food. Patients who are inclined to steal the food from others are placed at tables together and are especially watched over. Working patients are so placed that they get an extra amount of food to those who do nothing. Patients all come to the dining-room together at a given signal and no one is allowed to leave until all are through with their meals and the cutlery, etc., is properly gathered up to see that none is carried off.

In order to give some idea of the per capita cost and its gradual increase we have taken one day, May 2 in each year, covering five years.

May 2, 1914, the cost of meals served was \$91.69 for 840 persons. The total number of meals served was 2520; averaging .0364 per meal. For the officers, nurses and attendants and employees we served 369 meals; averaging .0587; for the patients, averaging .0326.

May 2, 1915, taking the same number of persons our total cost was \$105.65 per day; the total per capita, .0419. The officers, nurses and attendants, .0672, and the patients, .0376.

May 2, 1916, the total cost was \$110.16, the cost per meal, .0437. Officers, nurses and attendants, .0722; patients, .0388.

For the year 1917 the cost per day was \$135.31 and the cost per meal, .0537. The officers, attendants, etc., .0859 and for the patients, .0482. For the same date of the present year the cost per day was \$154.52; total cost per meal, .0613. For the officers, attendants, etc., .0984 and for patients, .0549.

You will see from this the gradual increase since the war began and how much the prices have gone up, practically 75 per cent. I may state that the rate of potatoes was the same during these four years as they were raised on our farm and the price charged was 40 cents per bushel. Each year we have had to buy potatoes from early in May, which made our cost per capita much more. This year our farm has produced enough to carry us through

until we have potatoes again. We grow so many vegetables and furnish so much from our farm for patients that the rates quoted are considerably lower than if we had had to purchase all these goods.

I have brought with me a sample of how our prices are worked out in our Ontario institutions. This work is all directed from the management at the Parliament buildings.

The proper cooking of food, its service and conservation are among the great problems with which we have to deal. Where there is no regular dietitian the chef practically has to be superintendent of his department. He plans the menus, the requisitions, and the work for his department (the physician being responsible for the special diets). He has to be responsible for his kitchen, cold storage and general equipment. It is necessary that he should be constantly on the alert to see that everything is kept in proper condition, that his assistants do their work in a cleanly and economical manner; and to see that the food is properly cooked, and sent from the kitchen so as to be served in a nice manner when it arrives from the wards. We do not make our chef responsible for the food after it leaves the kitchen. The supervisor of each ward is responsible for the proper service of the food when it is brought in. It is very important that the chef be a competent person, capable of working harmoniously with the officers of the institution, to oblige them whenever it is possible and make everybody feel that they are working together in the interest of all.

We all realize the importance of serving a well-balanced diet. There are none of us probably but have seen patients suffering from the lack of some important article (possibly vitamins) in their diet that they probably do not care to eat, and those looking after them were not solicitous enough for their welfare to see that they were supplied with the kind of diet that is requisite for good health. Personally, I have seen quite a number of cases of scurvy arise in patients who refuse to eat vegetables. Their peculiarities were not reported, with the result that I have mentioned.

Since writing the foregoing I have received a brochure entitled "A Proposed Basis for a Dietary for Hospital for the Insane to Meet War Conditions," prepared by H. J. Sommer, M. D., and P. Saha, M. D., Blair County Hospital of Hollidaysburg, Pa.

This pamphlet meets the food problem in an excellent manner and has arranged a number of proposed dietaries for working and custodial patients. I think it merits our careful attention and will give us a basis for working out many reforms in our food conditions, as it is all on a scientific basis.

In Ontario, Canada, the following letter has been sent to the superintendents of all the county houses of refuge and all the institutions receiving a government grant. It speaks for itself:

"TORONTO, March 22, 1918.

"MY DEAR SUPERINTENDENT:

"One year ago to-day a letter was addressed to you asking your help, and saying 'The need for increased production of food is real and urgent.' A splendid response was made to that appeal.

"If the need of food was great last year, it is ten times greater this year. Last year Germany only was on rations. This year Britain is on rations, France is on rations, Italy is on rations. The British are denying themselves and going hungry. Starvation stares the French, Belgians, and Serbians in the face. Famine threatens the Italians.

"Our Allies depend on Canada and the United States for food. They are trusting to us. We must not fail them.

"If you have a farm, or if you know anybody who has a farm, see that at least five more acres of wheat are grown on that farm in 1918 than in 1917; and grow in your garden all the potatoes, peas, beans, beets, onions, carrots, parsnips and other food that you can grow, and do not let one foot of earth lie idle this year anywhere in your township, village, town or city.

"Every head of cattle, every sheep, every pig, every chicken we can raise is wanted, and badly wanted.

"Under Almighty God our hope of final victory and rightful peace is in the hands of our farmers, as truly as it is in the hands of our munition workers and in the hands of our fighting men.

"Everybody can help—men, women and children.

"Do not waste any food—not a crumb.

"Be a leader and get everybody to help."

This work requires us, no matter what our nationality, to work together, not only in feeding our people properly, but at the same time by paying careful attention to conservation. Save a certain amount and the multiplication of that saved in all our institutions will be a very great asset for our nations.

Need I say more? Only this! In carrying out the solemn duty of doing our very best for the dear people God, in His Providence, has committed to our care, that we realize in like manner the importance in this crisis of doing all we possibly can for food production, and especially food conservation.

## PSYCHOSES IN MENTAL DEFECTS.

By ALFRED GORDON, M. D., PHILADELPHIA.

The present series of cases embraces all degrees of mental deficiency except idiocy. There were three imbeciles and 34 individuals with a mental status inferior to normal. Morons constituted the largest majority (24). The psychic disorders as they were manifest in the (37) cases presented themselves under two chief categories. In one, there was a greater or lesser intensification of the pre-existing mental characteristics which formed the basis of the constitutional make-up of the defects. In the other category, there were present psychoses common to all persons.

*Group I.*—Fifteen individuals presented during a period of five years at various times marked accentuation of their fundamental defective features in intellectual and moral spheres. *A propos* of various emotional factors, such as fright and minor accidents, there was present a decided intensification in the deficient mode of feeling and acting, also in the reaction to external stimuli. First of all, there was a definite arrest in intellectual acquisitions. One of the individuals during a process of mental training, which, as is well known, progresses in such cases only by small degrees and in an imperceptible manner, became listless and commenced to forget the slight amount of knowledge of arithmetic which he had acquired after laborious effort during a long period of time. It was also noticed that at times he would exhibit outbursts of violent anger with impulsive acts, by far more intense and more prolonged than prior to the accident. The former timidity became more pronounced; while he used to be very shy and hesitated greatly to face strangers and speak to them, now he isolated himself almost completely and absolutely refused to converse with anyone outside of his immediate relatives. Formerly he showed a certain degree of brutality towards his sisters and brothers. Once, for example, he attacked his older sister with scissors because she refused to hand him quickly a part of her apple. He inflicted an injury to her arm and while the latter bled he stood immovable and laughed. Since the acci-

dent, during a period of three months he was unusually violent in his attacks on his relatives, including the parents. Upon the least refusal of gratifying his absurd wishes he attacked mercilessly anyone who happened to be near him; he would pick up heavy objects, such as vases and irons, and throw them, irrespective of consequences. Once he inserted his teeth into his mother's arm with such force that for several minutes it was impossible to remove him, in spite of the fact that the victim kept on screaming from pain. He became so unmanageable during these outbreaks that he had to be kept in bed, under restraint. The condition lasted three months, during which period of time it was impossible to make any progress in the mental training which he had been undergoing prior to the accident. Gradually the condition became ameliorated, the violent impulses became less and less pronounced and the boy returned to his former mental state, which only then made the resumption of his training possible.

In three boys of the same group after slight accidents and in four boys after a fright in addition to an arrest of progress in mental training, there was also an increase in pre-existing tendencies of various character of a serious nature. Sexual perversion, such as fetichism, Sadism, exhibitionism and homosexuality, was quite marked and very frequent police arrests followed. In five cases, in which the mental status of the defective individuals was not wholly understood by the parents, bodily punishment was not infrequently inflicted by the latter when the children have been unable by reason of their deficiency to carry out orders. The result was that an accentuation of the fundamental abnormal characteristics became very conspicuous. Great irritability was the most striking symptom; impulses of the most unusual kind followed. Moreover, in three cases there was a mild, delirious state accompanying each outburst of passion, of anger, or following a violent masturbating act. They soon recovered from the delirium. Very brief periods of confusion were also observed in some of this small group of individuals during their morbid impulses. One girl of 13 was severely punished by her older brother for a trifling offense. Immediately afterwards she was thrown into such a state of depression that for hours she remained in her bed refusing food. Then suddenly she jumped off the bed,

picked up a poker and attacked her mother, taking her for the wrong offender. While striking her she talked quite incoherently so that she could not be understood. About 20 minutes later the condition disappeared. During a period of four weeks she had frequent outbursts of fury with a desire of attacking far more violent than formerly, although she was always subjected to abnormal impulses.

The following deductions may be drawn from the observations concerning the 15 cases composing the first group: Following some emotional factor the defective mode of thinking, feeling and acting becomes intensified. The usual want of parallelism between the emotional and intellectual elements of the personality becomes accentuated; the inhibiting power of intelligence over the moral personality is reduced to a minimum; impulsive acts may reach their maximum in intensity and frequency; there may be either an increased emotivity with exaltation, during which extreme anger, violence and brutality are conspicuous, or else emotivity with greater depression, during which timidity and shyness are extreme and a tendency to solitude is striking. In all cases, morbid tendencies become more conspicuous. It seems that the cerebral centers, which are the source of ideas and of their association, are further reduced and withdrawn from the chain of mental activities; they now present not merely a deficiency, but utter collapse. The activities which otherwise in defective individuals are the result of a feeble struggle between feeble conscious reasoning and claims of passion are now entirely out of the field of this struggle.

*Group II.*—Twenty-two individuals constitute this group of defectives. Either following some special etiological factor or without an apparent cause, symptoms characteristic of classical psychoses developed. In the majority (17) the onset of the psychotic manifestations was preceded by some somatic or emotional disorder. Influenza, profuse diarrhoea, measles, mumps, bronchitis, on one hand, sudden fright and slight accidents, on the other, were all present.

The psychoses observed were: Maniacal and depressive states (12), paranoiac states (3) and delirious or confusional states (7). There were more depressive than maniacal cases (9 to 3). This category included all adult cases. In the depressive sub-

group the depression was not as profound as is observed in individuals with a former normal mentality. The sad appearance, pale faces with drawn features, expression of humility and deep suffering, complete immobility—this was the habitual picture characteristic of cases with mental depression. At no time were all these symptoms combined in the defectives. Those that were present showed a shallowness, a superficiality. On the other hand, none of the patients presented during the entire period a depression or a state of anxiety, such as are found in painful emotional states; there was no lamentation, no moaning, no exclamation—all of which are observed in cases of agitated depression. Indifference, apathy and indolence were all present, but at no time were there delusions. The latter were absent even in the most pronounced cases of depression, when the patients isolated themselves for days and even refused food. There was no case of true melancholia with unsystematized delusions of self-blame or of unpardonable sin. There was no tendency to suicide in any of the cases. The absence of delusions is to be expected in depressed defectives, if we take into consideration the elements and the underlying psychology of ideas and special interpretation of conceptions which require mental elaboration of complete character.

The maniacal cases presented special features worth mentioning. In one of them was an early violent outburst. A man of 27, who up to that age presented the usual characteristics of mental deficiency, developed suddenly, after a slight accident, a most pronounced maniacal state which lasted six weeks. Restlessness, talkativeness, increased rapidity of thought and verbal expressions, and increased motor activity, were all present, but they all bore the stamp of the previous mental state. Owing to the limited association of ideas there was no characteristic coloring, but there was one feature in my patients which deserves special mention; it was so constant that it may perhaps be considered of some diagnostic significance.

In individuals previously normal during a maniacal period, opposing ideas may be easily brought out because of the easy association of ideas, or else because of the restraint in which such individuals are held. In these cases any opposition to the patients' wishes brings forward an intense feeling of self-esteem,



followed by a strenuous protest against the opposition. Moreover, owing to the fact that the thoughts flow in great rapidity, the states of opposition and protest are not lasting and they are quickly substituted by other emotions, pleasurable ones among them. In the defectives, on the contrary, opposing ideas were not readily called up and when they made their appearance they were feeble. On the other hand, if an opposing idea happened to be conspicuous it persisted with great tenacity for some time. It was also observed that the above-mentioned feeling of exaggerated self-esteem as a consequence of enforced opposition was not at all as intense as we find it in non-defectives. Neither did I find the rapidity of transformation of psychic energy into multiplicity of associated ideas such as we observe in non-defectives. Again, owing to the underlying limitation of intelligence in general there was absent the quickness of comprehension, of wit or humor or sarcasm, which is so characteristic of maniacal exaltation. Accordingly, I failed to find here the manner of expressing in especially choice language, or hasty acts ill considered, or especially strong impulses, or special desire or longing for pleasurable emotions, which are all so typical of maniacal individuals. Briefly speaking, the psychomotor side of exalted mental activity was expressed here in a lesser degree than in cases of mania occurring in individuals with a previous moral mentality.

Another interesting symptom is found in the hallucinations. Contrary to the usual absence of hallucinations or to their fleeting character when they are present in maniacal attacks, here in the defectives hallucinations occurred more frequently and were more persistent. Moreover, in two cases the patients acted upon. A girl of 12 in one of the maniacal attacks of an unusual intensity saw "ugly faces" and was so frightened that she picked up a cup of very hot milk standing on the table and threw it at her sister standing in front of her. The other patient, a girl of 16, saw "the devil" and was in such a state of fright that she ran out of the house and while running kept on looking back and screamed as she saw the devil pursuing her. Illusions were constantly present in all the cases.

The depressive and maniacal outbreaks in various individuals did not run a parallel course as to their frequency and the mode of repetition. It was observed, generally speaking, that there

were more individual phases of depression than exaltation. Two of the maniacal patients had but one attack of exaltation during a period of several years and only one patient had three attacks during two years. The depressive attacks, on the contrary, were frequent and in some cases very frequent. No patient of the series, however, had alternating attacks of one and of the other form of the manic-depressive psychoses. In the depressive cases there were only periods of depression; in the maniacal ones I observed solely periods of exaltation.

Paranoid states were present in three cases. Here disturbances are no more expected in the emotional and psychomotor spheres, but in the ideational realm. As the latter is originally of an inferior character in defectives any pathological modification of it incidentally occurring must per force be of an unusual composition. The disturbance of critical power, which plays so great a rôle in the formation of the systematized delusions, shows itself naturally in slight reflection and in superficial elaboration of ideas and deductions. For the same reason, the formation of delusions is not so easy or imperative, while in the normal type of paranoia the latter are formed with the greatest facility and readiness. The elements of the delusions which ordinarily develop out of imagination and defective judgment, assisted by errors of logic, are all here fundamentally defective and lead not only to abnormal creations, but are also defective in their abnormality; and accordingly the depression and apprehension which are constantly found in paranoiacs are not and cannot be as profound and as disturbing to the patient as in the habitual cases of paranoia. The characteristic abandonment of the patient without control to the delusional conceptions is not so striking here as in typical paranoia, because the ideational associations are here fundamentally defective. The reactions produced by external impressions are not as profound as in ordinary paranoiacs, as their relation to the originally defective individuals are not only perverted, but are defective in their perversion. The same peculiarity was also observed with regard to hallucinations. When the latter were present they were feebly used by the patients for the elaboration of their delusions, contrary to what we observe in the majority of cases of typical paranoia in which the hallucinatory sphere is greatly implicated and is used for the development of delusions.

The character of delusions and hallucinations in paranoia makes the patient live in a world of errors and deception which are so characteristic of the disease; but by reason of defective ideational associations in mental defectives the errors and self-deception to which their delusions and hallucinations lead cannot be striking and conspicuous. Herein lies the substantial difference of the morbid states of non-defective and defective paranoiacs. When one considers the evolutionary period of life in a future paranoiac, one assists at a gradual change of the personality which later becomes a disease. One observes how all perceptions of the external world in early life have a special relation to the individual, inasmuch as he very early commences to consider them as facts which fundamentally concern his own personality. This is intensified by his inherently vivid imagination. As is well known, the paranoiacs belong to the dreamy, romantic and eccentric category of individuals, who with great facility elaborate ideas which at first remain in a latent state, but later develop into delusions. Such characteristic features underlie the real foundation of a future paranoiac. They show a constitutional abnormality of the character. On such a morbid basis, with the gradual growth of the individual, multiple impressions arising with age and accidental occurrences are all apt to create erroneous conceptions of the external world. At first there are only presumptions and suppositions, but later delusions and hallucinations.

When we consider the development of the personality and character in defectives, the observation changes. We fail to find here the special personality with eccentric tendencies; there is no intensity of imagination with regard to external impressions; there is no special tendency to refer the latter to himself or to herself; there is no rapid formation of imperative ideas; suspicions to create rapidly erroneous conceptions; hence, delusional ideas are not easily developed and when they do arise they lack in depth and in elaboration. Continuing the analysis of the comparative picture in both classes of paranoiacs we find a further difference. The phase of transformation of personality which is usually present in the advanced stage of the fully developed disease is totally absent in the defective cases of paranoia if one has the opportunity to observe the individual during a sufficiently

long period of time. The absence of this phase finds its explanation in its very nature. As is well known, it is characterized by excessive development of exalted ideas concerning the patient's own personality. As for the development of this manifestation, which becomes in fact predominant over other ideas, an extraordinary elaboration of ideational processes is essential. As indicated above, the latter cannot be expected in defectives, hence the phase of transformation of personality must correspondingly be totally wanting.

In pursuing further the development of the subject, the final stage of paranoia must be considered. The terminal period of the disease is characterized by a gradual development of mental weakness with gradual fading of the delusions and hallucinations. In the three defective individuals of my series such a phase was not observed. When the hallucinations and delusions began to disappear there was no gradual diminution in the intensity of the faulty beliefs or any change in the interpretation of the ideas or images, but a sudden disappearance of both for a brief period of time and later a reappearance of the same, then again a disappearance and a return. This occurred several times in succession, and then finally a total abolition of both took place. Moreover, there was no genuine diminution of power of reasoning; otherwise speaking, there was no real dementia such as we observe in paranoia. It was therefore no terminal stage, so to speak. The patients merely exhibited the same mental attitude as prior to the outbreaks of the paranoid state.

If we recall all the characteristic features of the various phases of paranoia, and consider the incompleteness of the most important manifestations with the lack of depth in each of them by virtue of the fundamental defect of ideational processes in defective individuals, we are bound to admit that there is no paranoia in the latter. The disease as an entity cannot develop in them for the above reasons. Delusions and hallucinations of a paranoid character may occur in defectives, but their development and their relation to the defective personality, the entire attitude of the individual to the external world, the course of the condition and the termination of the latter, are all not of the kind which we observe in the classical psychosis. Not paranoia as a clinical entity, but paranoid states are met with in individuals with mental deficiency.

The last sub-group of my series comprises seven cases with delirious or confusional states. Three individuals were convalescing from influenza, one from typhoid fever, and in three of them a fright had preceded the onset of the mental disorder. Five patients had delirium with confusion, two only confusion.

In confusional states the mental operations are disintegrated. The ego no longer presents a union of individual elements of the mental mechanism. The ideas are consequently vague and ideational association is abnormal, so that a confusional individual uses words without special meaning to him; of his former ideas and conceptions only glimpses are left. He expresses his fragmentary ideas and notions in a demented manner and therefore without all associations, so that purposeful acts are not possible.

When we attempt to find these diagnostic elements in mental defectives we observe that not only they are present, but they are in the most intense and conspicuous form. Irrespective of any superimposed psychosis the mentality of these individuals is characterized essentially by a quantitative and qualitative deviation from normal. Appreciation and meditation are not only superficial, but abnormal. There is a fundamental defect in association of ideas, so that the acts are of a reflex nature. The whole life of defectives, generally speaking, is composed of incidents of an instinctive nature, as judgment and will power are wanting. When a confusional element is added it stands to reason that defective ideas will be still more vague and ideational associations more abnormal. A confused defective's words will have still less meaning to him than in a formerly normal individual. If in ordinary cases remnants of former ideas and conceptions are left, in a defective who is under the influence of a confusional outbreak the sentences uttered and actions executed show an absolute lack of such remnants and give the impression as if the individual were devoid of all thinking power. If in an ordinary case of confusion, the individual acts in a demented manner; a defective individual in such cases behaves like an imbecile or idiot.

In some of my cases to the confusion was added a delirious element. As is well known, in the latter there is a deep involvement of the sensorium, especially in the form of hallucinations and the suppression of the faculties of attention and reflection.

The disturbed sensorium creates delusions. In the five defective individuals of the series there was confusion with a delirious state. The attitude of these individuals, such as appearance, motions with the hands, sudden and repeated turning of the head, suggested the existence of auditory and visual hallucinations. As to the delirium itself it was throughout in all the cases of a muttering character and at no time in the form of anxious excitement. Since the faculty of reflection based on association of ideas is rudimentary in defectives, and an involvement of the sensorium cannot be deep in these individuals, the elaboration of delusions and hallucinations cannot, fundamentally, be strong and conspicuous. Thus the muttering and not the excitement with anxiety of the delirium in ordinary cases was to be expected. The muttering was unintelligible, fragments of words could be heard occasionally; the patient preserved a uniformly quiet and undisturbed attitude throughout the delirious states, which in some cases occurred several times.

One of the most interesting phenomena in the last group of cases was that the mental state of each individual suffered considerably following each attack of confusion or delirium. The individuals' intellectual *niveau* became greatly lowered and all the faculties and functions depending on it were correspondingly affected. The inhibiting power was reduced to a minimum, and for this reason the defectives who possessed an emotivity with exaltation exhibited unusual impulsiveness, extreme anger, violence and conspicuous brutality; while those who possessed an emotivity with depression exhibited extreme timidity. Those who prior to the psychoses showed various perversions, now exhibited a deeper development of the latter.

*Conclusions.*—The present study reveals the fact that the intellectual and emotional peculiarities and abnormalities of defective individuals become more conspicuous when additional psychotic disturbances are superimposed. Each individual characteristic in the various faculties, which being combined constitute the mental personality, becomes mobile and is given a greater opportunity for displaying its influence upon the defective's attitude, behavior and general mode of acting and feeling. To the observer is given an opportunity to measure and estimate the degree and intensity of deficiency in the various characteristic

features of the defective individual, because of its modifying effect on the habitual manifestations of a psychosis. The impress that mental deficiency leaves on psychoses, viz., depressive, maniacal, paranoid, delirious and confusional, is that they are modified in their typical manifestations because of the fundamental defect in the formation and association of ideas. On the other hand, the psychoses have reciprocally their modifying effect upon the basal mental deficiency; they produce such a profound disturbance in the latter that the recovery from the superadded incidental psychoses is always followed by a deeper diminution of mental power in the original mental status. The reason of it probably lies in the fact that the psychoses disappear invariably more slowly than in non-defective individuals. For the same reason probably it is more difficult to obtain favorable results from therapeutic efforts. The prognosis is therefore more serious in psychoses of defectives than of non-defectives. When the psychoses disappear instead of recovery we witness a greater reduction in the intellectual horizon than before the psychoses had developed.





## THE NURSING PROBLEM AS RELATED TO PSYCHOPATHOLOGY.

BY RICHARD DEWEY, A. M., M. D., WAUWATOSA, WIS.

With a view of eliciting discussion of the conditions and prospects in the sphere occupied by the immediate caretaker, nurse or attendant upon psychopathic patients, I will endeavor to state some of the elements and factors concerned in this particular problem.

First, a few words regarding the available nursing forces. Considered as a whole, this situation may be briefly outlined as follows: There is in the United States a total of between 80,000 and 90,000 registered or graduate nurses—the head of public health nursing at Simmons College, Anne Hervey Strong, puts the entire number at 66,000—of these 7000 are already enlisted in Red Cross War service and Surgeon General Gorgas is now asking for 5000 more. No one can forecast as to what the future has in store; but if the enemy is not overcome during the present year and if the victory is not obtained which alone can end the intolerable attempt of Germany to dominate and terrorize the world, we may see one-half of our entire force of nurses drawn into the employment of the military hospitals. The proportion of 12,000 nurses for each million of soldiers is considered requisite by the authorities. Accordingly, the present force of 1,000,000 soldiers requires 12,000 nurses; 3,000,000 soldiers would require 36,000 nurses. It is understood we face the possibility that even 5,000,000 may be required, which would necessitate a force of 60,000 nurses. To meet this demand, a school has been established at Vassar to which the Red Cross gave \$75,000 and the government is planning an army school of nursing at cantonments. A 25 per cent increase of pupil nurses has taken place, but all that can be done will leave us short. Among our civil population, there are 3,000,000 persons sick and in need of nursing every day in the year, 90 per cent of these are in private homes. The loss to the nation in a year from this source is \$1,500,000,000, and half of it is preventable sickness.

Now, turning to the nursing problem as it affects our especial field: the state hospitals and those of county and city. We have a situation which can but occasion grave concern. Not only is there a dearth of trained nurses for mental cases, but nurses of any kind are in demand far in excess of the supply. The care of more than 200,000 mentally incompetent charges of the state rests upon the shoulders of the members of this Association. We have heretofore carried on our work, under difficulties to be sure of various sorts, with some degree of success, but the difficulties are now intensified many fold and also greatly heightened by economic stress. It is the general experience that there is a constant diminution of numbers caused by resignations of attendants and nurses from the service, while far less than the requisite number apply or can be found to take the places that become vacant. Many of us have found that neither "love nor money" appears to be of any avail and the necessity for help becomes more and more imminent. It has been our ideal to develop a body of trained nurses for our hospital work, corresponding in efficiency to the nurses of the general hospital. Training-schools have been inaugurated and maintained increasingly from the historic epoch nearly 40 years ago, when Edward Cowles established the first training-school for mental nurses in McLean Hospital (in 1880). The example of the McLean Hospital was followed in chronological order by Buffalo, N. Y.; Flatbush, L. I., N. Y.; Poughkeepsie, N. Y.; Indianapolis, Ind.; Kankakee, Ill.; and a constantly increasing number of training-schools has been developed. An effort has been made under great difficulties to maintain these schools, but, in general, they have fallen off in numbers and some have been discontinued. It has not been possible to reach a point of development where the whole body of the nurses and attendants could be carried through the complete course, and fewer still remain in the service after graduating. My own experience in maintaining a training-school at Kankakee from 1887 to 1893 convinced me that a full course of training for the whole nurse or attendant body, corresponding to the course given in the general hospital, was not practicable. In working upon a curriculum, especially adapted for the state hospitals, I found that the entire technique of surgical nursing and sick nursing could not be applied to the entire body of nurses. The field of nursing embraces

within itself many specialities: surgical nursing, sick nursing in all its varieties, the nursing of mothers in confinement and children, the nursing of the tubercular, public health nursing, massage and hydrotherapeutics; and, in departments by themselves, public welfare and social service. Finally, the care of mental cases is in itself a specialty requiring as much of study and talent, though of a different sort, as any of the others mentioned.

In the recent reports of two of the state hospitals of New York—the Brooklyn and Manhattan hospitals—I notice particular mention is made of a special course of training covering a period of 13 weeks, which it has been sought with varying degrees of success to carry out with the general body of the nurses. A paper published in the *Journal of the American Medical Association*, by Dr. Philip King Brown, of San Francisco,<sup>1</sup> states that in 72 training-schools of California, mental nursing was only included in four. Dr. Brown's conclusion was that the present system of instruction is not well balanced. He recommends practical instruction in handling the sick, surgical cleanliness, administration of remedies and application of dressings, bath instruction and keeping of the chart. He is of the opinion that nurses should pay for their instruction and should not be boarded in the hospital.

In discussing training schools for state hospitals before the National Conference of Charities at Omaha, Neb., in 1887, the writer used the following language which may be regarded as still applicable to-day:

The training-school for attendants upon the insane, though in part an outgrowth of the training-schools for nurses, has an essentially different character—requires much that a sick-nurse does not need to know; while, on the other hand, much of the nurse's instruction would be thrown away on the asylum attendant. The persons who are willing to engage in the care of the insane as attendants do not possess the education and previous mental training which would be desirable, if attainable; and, therefore, their instruction must be of the most direct, plain and simple character.

Now, coming to the present day over a gap of 30 years, let us inquire: First, what are present conditions? Second, to what

<sup>1</sup> *Journal of the Am. Med. Assn.*, May 18, p. 1438: "Nurses and the War," Philip King Brown, San Francisco.

extent the courses of instruction of the general hospital training-schools is necessary to our especial purpose?<sup>a</sup>

We who have the field of mental nursing to occupy are all familiar with the embarrassment and lack of adaptation which the graduate of the general hospital training-school shows in mental cases, unless perchance she has gained experience in an institution for mental disease or had special training and instruction in such work. Indeed, the highly trained graduate nurse is often less fitted for oversight of the mentally deranged than many an untutored woman of common sense and kindly disposition. Who of us has not had nervous and psychotic patients or friends of patients who wished to avoid the trained nurse, who had such erroneous views that they objected to the very costume, and instead of being "healed" by the "seersucker stripes" were repelled? The well-starched cap and robe of white called up experiences in the past not of a pleasant sort.

Far be it from me to detract in the slightest degree from the conspicuous merit of the thoroughly accomplished and highly efficient presiding genius of the surgical ward, fever pavilion or operating room. I am only saying that the qualifications needed here are of another kind from those appropriate for dementia præcox or psychasthenia.

Here it is well to note the circumstances of a movement among the associations of trained nurses looking toward the formation of a class to be known as aides, assistants or attendants and to be auxiliary to the registered nurse.

In April, 1914, at a joint meeting of the American Nurses Association, the National Organization of Public Health Nursing and the National League of Nursing Education, these several bodies, representing about 50,000 nurses, passed resolutions requiring:

- 1st. The acknowledgement of the necessity for two groups of nurses and no more: the trained nurse and the trained attendant.
- 2d. A pledge of cooperation in any plan which would provide suitable training for attendants.
- 3d. A belief in standardization and protection of the attendant by law.

<sup>a</sup> "Training-Schools for Attendants." Proceedings National Conference Charities, Omaha, Nebr., 1887, p. 221 *et seq.*

This we learn from the publication of the Proceedings for 1914 of the National League of Nursing Education. Agitation of these proposed changes has produced discussion in the General Medical Board of the Council of National Defense, and the attitude toward the question of creating a new class of nurses' aides or attendants is expressed by the following resolution:

"The committee believes that short-term courses are likely to result in positive harm. Their introduction into hospitals regularly maintaining training-schools would tend to break down the machinery of nursing education. Furthermore, the energies of women, who would otherwise take a thorough training which would make them more useful factors in the war, might be diverted to special short-term hospital courses."

They also state: "We place ourselves on record as of the opinion that the mentally as well as physically sick should have the advantages of the services of a fully trained nurse." I would not undervalue training, as we have seen in the present war the uselessness and inefficiency of the amateur. (Out of 1500 women volunteers in a recent case of need—so Professor Stevens tells us—only two came forward in the real emergency.) The claim of full all-round training, however, for all may be regarded as a "counsel of perfection" when we reflect that not only is the supply of trained nurses insufficient for the needs of those in the community who are so fortunate as to be able to command their services. On the other hand, in private homes of the moderately well-to-do and in general hospitals, public and private, thousands are in equal need: yet the supply of graduate nurses is so limited that the creation of a body of less expensive trained "attendants" or "aides" seems imperative.

Furthermore, the state hospitals for the insane have at the most only an inadequate sprinkling of graduate nurses, a wholly insufficient body of pupil nurses, and are obliged to utilize as best they can the wholly untrained for the care of the great majority of their inmates. In institutions where a training-school is maintained, the number who complete their training, as compared with the demands, is insignificant. Those employed as attendants are a shifting body of individuals, only a small minority of whom can be said to possess the qualifications and the willingness to give themselves permanently to the duties of nurse or attendant upon the insane.

These facts make it necessary to consider whether a class of nurses of a grade less completely trained than the registered nurse and yet qualified for ordinary service, educated and standardized, and registered, or licensed by the state for their special field of usefulness, would not be an improvement upon the present rather chaotic condition.

NOTE.—Since the above was written, agitation of this subject has gone on apace. At the present time (February, 1919) there is heated discussion over a bill that the organized nurses have introduced in the Legislation of Illinois to create a body of "junior" nurses who shall have a course of 18 months' training. This law further provides that "a junior registered nurse may nurse the sick or disabled, but may neither engage in public health nursing, act in a supervisory capacity in a hospital or similar institution, act as an instructor or in a supervisory capacity in a school of nursing, nor act as an instructor or in a supervisory capacity in public health service or any other like service." Moreover, she is not permitted to nurse in a hospital except "*when she is under the immediate personal supervision of registered nurses*" (italics mine).

This has the appearance of an attempt to develop an aristocracy or privileged class of nurses. The "junior" or "practical" nurses will form a "middle class," and it is to be feared the "proletarians" will come in and reduce the whole system to chaos!

## DISCUSSION.

DR. BRUSH.—I do not know that I can make myself entirely heard above the noise overhead, however I will try.

I am placed in the position of having to disagree with my friend Dr. Dewey. In the many years I have known him I have followed in his footsteps with a great deal of confidence, but I believe there is no calling in the world that requires greater intelligence and a higher order of nursing than mental nursing. We do not admit a nurse to our training school who has not at least a high school education, and if I could get them with a college education I would be glad to do so. We require them to take a full course of training in our training school; we required that they should take, before the war, 18 months training in a general hospital; since the war 12 months, giving them two years in our own school. Our attempt to train attendant nurses has met with the same experience as Dr. Dewey gives; we find there are some who want to do a great deal in a very short time; they belong to the class who are willing to take a correspondence course in nursing and hold themselves out as trained nurses; they belong to the class that do more mischief than good. I believe we can do a great deal of harm if in the emergency of war we lower the standard upon which we admit nurses to our training schools. Now it may be that the times are such that we will have to put a degree of intensive nursing into a few who

are willing to go into the hospitals. I know the demand is very great. I came here with a request from the Red Cross, that I ask you gentlemen to get along with as few nurses, to keep nurses as short a time as possible in your wards, especially on special cases, so that they can be released for war work; to those of you having private patients under care to discourage the continuance in charge of a nurse longer than is absolutely necessary, and even to discharge the nurse a little earlier than is perhaps always wise. There are women of wealth who have what might be called the "trained nurse habit"; they want a nurse with them all the time. I know of several ladies who have trained nurses as their companions. One of them told me: "I cannot go without my companion." I said: "There are hundreds of women in Baltimore who would be glad to take the place of your companion and do just as well as she does and you could release your nurse for war work, for which she is badly needed." Some are too selfish to listen. We have sent some of our nurses over on the other side—five are over there now. If we can get some of our nurses who are graduates to go into war work, and who are engaged in work in which they are not absolutely required, we will be doing a little of our duty.

DR. BURR.—Standards of every description save the one standard of military effectiveness have deteriorated—been shot to pieces. I use "effectiveness" in place of "efficiency"—a word which I have come to abominate. Standards got a terrific blow between the eyes when the Kaiser set his cloven hoof in Belgium. The relation of nurses to patients; the relation of man to man; the relation of employee to employer; all those things we have prized—all have been damaged and damaged very badly by that frightful departure from decency and the square deal. Dr. Brush talks about keeping up standards; says that he is going to do it, but, believe me, he won't; he will take what comes to him whether from high school or no school at all, or he will shut up his shop. I know whereof I speak. This war has made an excuse for a lot of differences between the attendant and the nurse and the superintendent; you know this just as well as I do. The high cost of living—we all know the high cost of living does not greatly affect the employee of a hospital whose maintenance is given as part of the wage. One of our nurses made a statement to that effect to my stenographer. She said: "I thought that was a problem that did not concern you to any extent." I find sometimes that it is shoes; very frequently expensive gloves have figured as being a necessary bill of expense due to the war. While of course we cannot go without shoes, it is possible that economy in gloves could be exercised where it is not. It is very difficult, but we have got to carry on the work and do the best we can with the material at hand, and Dr. Brush need not exalt himself so much; he is going to take what is set before him and ask no questions for conscience' sake like the rest of us.

DR. GORST.—Dr. Southard's high grade psychopathic nurses from the university is a very fine idea, and Dr. Brush's class of nurses, none below the high school type, is a beautiful idea, but if you will go to the training schools of the general hospitals all over this land you will find the nurses at the

present time are far below the high school, and if you will go to the state hospitals who are running training schools, you will find a whole lot of them a long ways below the high school grade, and if you will go to the state government and to the state boards of control throughout the United States practically, you will find that the policy has been for a long time to hire about the cheapest help they could possibly hire for the purpose of giving care to the insane. They spend millions of dollars for the purpose of building domes and large buildings, but they spend very little for the purpose of taking care of the insane after they are in them. For several years as superintendent of an insane hospital in Wisconsin, my report recommended to the State Board of Control certain things. We did finally get a training school for girls after five years; we had quite a successful school; we had very good care on the female side of the house and on the wards on the male side where the patients were in bed. We had most of our trouble because we had hired men as attendants and charge attendants who knew little and cared much less; that is the kind of men that have been hired by the state boards of control for the care of the insane for years and years.

When we can get to a condition where your Board of Control will consider that it is just as necessary to take care of the patients as it is to build a dome on the institution, we will have gained something. When the politics of the state will look after the real necessity of caring for the patients as much as they look to pleasing the people of the state by a fine institution you will have gained something more. When you spend \$15,000 per bed to take charge of the children with a brain that cannot be trained and you hire men for \$20 or \$25 per month to take care of 60 or 75 insane on a ward, you have not balanced the care of the insane in the state very well.

DR. DEWEY.—I think there is nothing more, as the remarks of Dr. Brush were answered by discussion. One thing that seems to me to need attention is the endeavor to find some means to establish standard lines of demarkation in the nursing profession. One important thing that has been mentioned is the matter of companionship; there is a considerable percentage of all the patients suffering from psychoses who, for the best results, need that more than anything else; a companion—some one congenial, adaptable, to help them with suggestions; to attend to matters that do not otherwise receive attention and can not but benefit the patient.



## THE COMMUNITY MENTAL HEALTH MOVEMENT AND ITS PROBABLE DEPENDENCE FOR SUCCESS ON A HIGHER STATE HOSPITAL STANDARD FOR WARD EMPLOYEES.

By SIDNEY D. WILGUS, M. D., ROCKFORD, ILL.

### STATE HOSPITAL SOCIAL SERVICE SUGGESTED.

The first statement that state hospitals might well broaden their field of activity or had come "To the parting of the ways" was delivered by Mr. Homer Folk, to whose foresight and constructive endeavor in many directions all state hospital people should be profoundly grateful. This warning fell from his lips nearly 15 years ago, when he stated as an opinion that the hospitals must broaden out and be powers for good outside their boundary lines else deteriorate with "dry rot." The suggestion met with favorable comment at the time and afterward, and yet one can survey the field to-day and see it has borne but little fruit. This is so because the visions of the idealist travel faster and farther than the material limitations of practical life allow. Ideals are like castles in the air, but they can be materialized if after dreaming them we get back to the brick and mortar of life and after removing obstructions build real castles patterned after the visions.

### THE APPARENT ALTERNATIVE.

Assuming that the plan has virtue in it, come back from the dream of the mental health exponent to examine the nature of the obstacles preventing the full development of the plan and study how to remove them; the alternative, quite impossible, seems to be to allow progressive tendencies to pass into other hands, for progression there will be. Within a few years social service has become recognized by departmental establishment in nearly 200 general hospitals of this country, and if the state hospitals fail to profit by this example and precedent the initiative will simply pass into other hands, leaving them more custodial than ever.

### PRACTICAL REASON FOR DELAY.

Before a management can undertake to greatly enlarge its field of operations the feeling must be present that the base from which it operates is as safe and in as good order as the military base of an army commander. Very few hospital officers feel that way now, and while away from their institutions each man's head bears a crown of thorns. Under this condition of affairs can any such afflicted officer be expected to think seriously of the considerable expansion of his sphere of activity this plan entails? The answer, of course, is in the negative, so discussion of the cause of this disability, the ward service, is next in order.

### THE UNSATISFACTORY WARD SERVICE.

All of us very well know that the attendant's calling should be considered a specialty of no mean importance. It is a trade or calling, the grasp of which demands several months' training. This has been fully recognized by superintendents these many years. Yet we know also that the ward employees are unstable as a class and in this fail to meet a fundamental requirement for good results. The training school for nurses was initiated 35 years ago to stabilize the service, but the result was achieved to minor (if not negligible) extent only. A questionnaire to show the figures concerning changes (and hence low efficiency) amongst ward employees was sent out just before the war and found the average number of changes in the attendant force in 60 hospitals in the United States and Canada was then no less than 75 per cent per year. Half of the attendant group changes several times per year. The replies therefore covered conditions very widespread, geographically and otherwise. Careful survey of the facts and figures makes the fact evident geographical location had little to do with the number of changes; neither did the size of the *customary* wages of \$20 to \$35; nor did the hours of labor have any bearing. The surmise that there existed some potent cause not yet fully recognized seemed well justified.

### TEACHING SERVICE VERSUS CUSTODIAL SERVICE.

The secret was not deeply hidden, for some parts of the public service were more stable, and it simply became necessary to com-

pare the facts concerning the relative services. Within the past few years it had been my fortune to go quite intimately into all of the state institutions of three states of the union and particular effort was made to ask concerning difficulties with attendants on one hand and teachers and guards on the other. It was soon found that the number of changes amongst state institutions employing guards for prisoners and teachers for boys and girls were far fewer than occurred amongst the attendants in the state hospitals. A little inquiry served to show that with practically equal working conditions the guards and teachers were *better paid* individuals and, on the whole, came from a more stable class of society, or else they felt that their reward for service was in proportion to the difficulties of said service. For one or both of these reasons the service in these quarters was certainly more smooth and harmonious and the end far better achieved.

#### QUESTIONNAIRE TO MID-WEST TEACHING INSTITUTIONS.

The questionnaire recently returned from 18 institutions employing teachers and guards contained some interesting facts. Twelve concerned institutions employing practically all female help and six practically all male help. In the former group 420 employees showed 120 changes or 30 per cent per year as contrasted with 307 male employees with 114 changes or 37 per cent per year. This indicates a somewhat higher rate of change amongst male employees. This is of particular interest as the females averaged \$50 per month (and usually maintenance) and the males \$70 per month (and usually maintenance). Therefore it would seem that a male wage of \$70 is less satisfying than a female wage of \$50. This is not surprising when we consider the customary additional burdens that the male of the species is expected to carry. Now to contrast the above with state hospital conditions we find a total of 727 teachers and guards with a turnover of 32 per cent in a year involving war conditions, whereas in the state hospitals we found a pre-war turnover of 75 per cent as something just ordinary and to be expected. With the plain fact here of twice the turnover in the state hospitals as compared with the others we find the wage in the state hospitals averages between \$30 and \$35 per month with the average in the other group nearly double, or \$60 per month. Kindly

note that the state hospitals with half the wage contribute exactly double the turnover.

Yet notwithstanding the great advantage in favor of the teaching and guard class I want to quote a pertinent and patriotic remark of Major D. C. Peyton of the Indiana Reformatory which carries a recommendation of all the managing officers in definite form: "It seems to me that state institutions and all other organizations should make the necessary sacrifices in order to contribute toward winning the war; yet *in order to keep the minimum number of competent employees to handle the state's business I think the scale of wages should be such as to attract the correct type of employees* to successfully handle the state's business, but each institution should endeavor to get along with the lowest possible minimum of employees." The superintendent of the Illinois State Reformatory, Mr. Scouller, seems to voice the sentiment of this class of officers in the recommendation to make the entrance salary not less than \$65 and maintenance, with a regular scale of increases to \$100 and maintenance. I cannot close this particular discussion without quoting an illuminating statement from the warden of the Michigan Reformatory which is sarcastic, humorous or pathetic according to one's point of view. Warden Fuller says: "We pay a thousand dollars per year and average fewer than two vacancies per year. We have no difficulty in filling vacancies as fast as they occur and usually have more than 100 applicants on the waiting list. I understand the state hospitals for the insane in the state experience a great deal of difficulty in keeping a full force of attendants and if you will address the superintendents you can obtain a great deal of valuable data along this line." Thus we see plainly in the statement of fact followed by quotations from state officials the relation between wages on the one hand and stability (efficiency) on the other.

#### THE LESSON TO BE GATHERED FROM THE TWO QUESTIONNAIRES.

It seems clear that the inducements needed for the hospitals, as for the schools, are those which will allow the average man to live and enjoy a normal life; a wage sufficient to allow a man to live in his home and support a family and yet have something left for entertainment and some for investment.

The old state hospital class cannot be anchored, as it is inherently as instable as the quicksand of the sea. It is of this same class that Alder speaks in one of his papers on social conditions and in this connection remarks that in certain New England districts the mills were forced to employ six men per year for each position in order to keep the positions filled. So to do our broader work we must go to a new class, the latter class, the group more stable, and offer the one necessary inducement, the greater wage, to take up this most difficult and yet fascinating work of caring for and upbuilding wrecked human lives.

#### WHAT IS THE PROPER WAGE?

Difference of opinion may arise about the size of this living wage, but that matter may be settled through consultation with investigators in social fields; the second questionnaire (*i. e.*, concerning teachers and guards) brought forth some important facts and correlated suggestions concerning wages; these are worth a second glance and are referred to at this time. Our high-grade employees may be given rent and supplies to some extent in lieu of cash and the cash equivalent for service might thereby be lessened. When the United States desired to meet such a problem in the ship-building program Congress hesitated not to spend millions of dollars for housing accommodations for the workmen. How far this plan can go in hospitals is a question, for men like to handle money and to spend it and the larger cash wage may be considered the most important item to meet the situation surrounding present conditions.

#### WITH STABILITY WHAT RESULTS ARE TO BE EXPECTED.

The great bulk of the inmates need not the nurse nor the group caretaker called the attendant, but the *individual* caretaker or *teacher*, and this is one of the points I have been leading up to, namely, the development of a stable service made up largely of educable employees in the shape of corps of nurses and teachers, few of the former and the bulk of the service of the latter. I use the qualifying word "largely" in the last remark for the reason that some few attendants may still be needed in a certain capacity to do simple, unskilled labor.

Granted a capable and ambitious superintendent safe in office and the staff he will soon assemble, what cannot be done with the aid of these two higher groups of fellow workers? One sees accomplished *within* hospital walls that which has heretofore simply been dreamed of, a service full of courtesy and of personal care; of the prevention of vegetative dementia; of the re-education of those neglected in the past; of the development of the productive power in which economy is an end sought, but in a rôle minor to mental health; of economy in help and in clothing and supplies not now possible—all this means the widest personal care of each individual and of that individual's belongings and of the state's properties and effects supplied and maintained for his benefit.

#### THEN THE SUPERINTENDENT MAY BROADEN HIS FIELD.

With such a dependable and efficient organization at home he may feel as he never heretofore has felt, namely, that his efforts and skill may be extended and applied through practical means to the betterment of the mental health of his community. His new organization will supply him with efficient, trained mental nurses and with hospital-trained social workers who may be given such outside postgraduate advantages as seem necessary for best results. When that time comes *within* the hospital precincts why cannot each superintendent develop and organize *outside* the hospital in his district: prior care; proper care pending commitment; proper traveling custody of the committed; encouragement of voluntary and emergency commitments; boarding out; after care; public clinics; cooperation with the courts and with other public organizations—all these and perhaps more in every town and community in the district?

#### ADDED EXPENSE (IF ANY) FULLY NEUTRALIZED.

Expense may be alleged by some to be prohibitive. To my mind this is absolutely without foundation in fact. One good teacher with ambition, pride, interest and skill is worth many of the kind commonly attracted now to our state hospitals. *Locally* there will be that saving of man power patriotically recommended by Major Peyton; the conservation of clothing, ward furniture, fix-

tures, supplies and food by these intelligent men will amount to a considerable item; the conservation of the productive power of inmates for their health and for the benefit of the state will prove astonishingly great; the courtesy and personal care now largely lacking and the higher grade of nursing facilities cannot be measured in dollars and cents, but should be recognized on their merits. Lastly when it comes to the operation of the superintendent's *district* organization founded on his better ward organization then I say that problems involving an immense amount of human misery and crime and the expenditure of millions of dollars are directly attacked in their home environment. Criminology, for instance, shows us that more than one-half of all criminals, paupers, and prostitutes are feeble-minded or insane. And if these people can be handled psychiatrically by the superintendent and his organization before they have become involved with the law the financial and other advantages are so obvious that no discussion is required. There are so many of these problems that this field organization may assist in attacking from the economic as well as the humane point of view that it is rather difficult to mention them all, but a few of them are herewith given in addition to the above: The prevention of insanity through early advice and perhaps voluntary treatment in a hospital for the insane or elsewhere; the prevention of insanity through eradication of syphilis and other diseases directly or indirectly affecting mental health; cooperation and advice with the courts in mental cases; scientific examination of alleged criminals and especially those pleading insanity as a cause for crime; cooperation with other public agencies for mutual investigation, information and advice; the establishment of clinics in all the towns of the district; the establishment of psychopathic wards in general hospitals; control of the propagation of the insane and defective at large, whether prior to being taken into custody or after parole, discharge or escape from public institutions. These are some of the points of economic and human usefulness of such an organization, but the field is so broad that undoubtedly others will occur to the managing officer once that his organization is at work.

## RÉSUMÉ.

So let it be repeated that the success of this plan for the hospital extension or community health work would appear to depend: (1) On stable constructive service at home; (2) the existence of this would seem to depend in turn on the employment of a class of ward workers as high in interest, ambition, pride and educability as the teaching class; correspondingly the reduction of the "group" attendant service to the very minimum; (3) to secure the higher class dependence simply lies on one factor—the living wage; (4) lastly the living wage, so called, spells economy in hospital management and the development of a hospital extension work with possibilities that charm the man with vision.

## DISCUSSION.

DR. SANGER BROWN.—In my opinion it would be eminently proper for this association to spread propaganda in the direction suggested by Doctor Wilgus' paper. The services properly appertaining to the nursing and attendants staff of institutions for the insane is of cardinal importance and satisfactory efficiency in this department cannot be expected unless inducements are offered in the way of living conditions that will attract individuals of integrity and intelligence to adopt the work as a permanent vocation. To accomplish this a very considerable addition to the sum now expended for this purpose will have to be made, but when the public generally come to understand the importance of this proposition, it is not unreasonable to expect that necessary funds will be forthcoming. Some of the states have already made admirable progress in this direction and it should be the purpose of this association to make these efforts general. I would like to see a symposium on this subject another year, or so soon in the future as the public mind is not so engrossed with the military situation as to enable it to give due attention to this important matter. As it appears to me, Doctor Wilgus' appeal is in harmony not in conflict with the training school.

DR. GORST.—I am very glad to listen to the last paper read. I am very sure that the reader expresses the experience of every man who has been in the position of superintendent of a state hospital for the insane. No one knows better than the man who has filled that position for a number of years, the truth of this paper; no one feels more than a superintendent who has charge of patients that he needs better assistance when he leaves the ward, than he does; no one knows better than the man who has filled the place of superintendent, that when he goes on the ward the next morning after sleeping through the night, that perhaps part of the male patients and some of the female patients have fallen down stairs; there is a broken bone or something has happened and you are unable to find out how



it happened or who did it; but you know, all of you who have had the experience, that the untrained, careless, cheap hired man is not useful. It is absolutely wrong for the state to spend millions and millions of dollars, as they do, in putting up fine buildings and fine equipment and then hiring the cheapest men they can hire who sit on the ward for the purpose of rendering care to the patients. You might better go without a superintendent if you could have good, careful men and women to take charge of the patients on the wards. You know all the troubles that come from the families of these patients, but you can't do anything; you know your employees have abused the patient and that it is absolutely wrong.

This society could stand for many things; it might very well take a stand in favor of an alienist examining every case that there is a mental question about, before the court sends that case to state prison, state reformatory, to a state school, or to any other state institution. One of the worst things I know of in this country is the sentencing by the court in many of the cases without any knowledge whatever of the mental condition. This society might stand for the proper mental examination before a court sentence is passed; it might stand opposed to the idea of the policies and politics of the state interfering with the professional part of the conduct of the institutions for the defectives. No state can have a chance to progress and give proper care to the inmates of the institutions where the heads are turned in and out every time the governor has an "ax to grind."

There are at present more than 280,000 feeble-minded persons; more than 70,000 are women of child-bearing age; less than 28,000 of those are under the care of the state. An increase in the feeble-minded has occurred every year; we have at least 7000 feeble-minded in our state; we have one state institution and we can take care of 1370, so we have more than 4500 outside. We are building, under the direction of the State Board of Control and the legislature of the state, an institution which will take 20 years to build, costing \$1500 per bed, that at the end of 20 years will take care of 200 persons. Our increase of feeble-minded in the state annually is more than 250. There is no sense whatever in spending \$1500 per bed for the care of a child whose brain cannot be developed and never will be.

DR. WOODSON.—I am not engaged in state hospital work, but I apprehend that the public is reasonably well posted as to the character of nurses that are employed in the state hospitals, and while it is no concern with me whether this resolution of Dr. Gorst's is adopted or not, I believe a discussion of this subject will have a tendency to bring about more discontent in the man connected with the state institution who thinks he is doing the best he can. If his state will permit him to give more money to get a better class of attendants and nurses he ought to do it. My state gave me the permission to employ whomsoever I thought best and to discharge them at my pleasure. Because wages are low it does not necessarily mean that the person must be inferior; because they are high it must not mean that they are competent. The thing to do is to feed your patients well and feed your employees well, and this can be brought about largely by raising the various fruits and vege-

tables. If you employ a man because he has political influence or if you employ a man because he asks more wages, that is not an indication that you are going to get more. I tell you you must feed your people well; I find that I can feed my patients one-half less by looking to my garden; we have two or three vegetables and two or three fruits every day in the year. I never saw a food consumed in a state hospital with so little waste about it as apples.

I do not agree with the speaker; the best way to keep help is to get help who wants to work.

DR. KILBOURNE.—I think we may have overlooked one point; it seems to me that the training school ought to have considerable influence in securing nurses for our wards. The profession of nursing is largely confined to young women: and we know that many work for little or nothing in many hospitals to secure their diplomas. After two years' work in our state hospitals, if they desire to become registered nurses, they can take a one year's post-graduate course in a general hospital with which we are affiliated; so that this course is a greater financial advantage to them than if the necessary training is all spent in a general hospital. I do not think it is altogether a question of big wages which influences them, but the advantages afforded them by our training school and the prospects of a useful and remunerative profession.

DR. HOTCHKISS.—We all know that wages constitute approximately one-third of the per capita cost of a state institution; we also know that per capita cost is the bugaboo of all institution heads, and how it is continually being put up to us. It is the one subject that you can always talk to a legislative body about. To criticize a per capita cost without taking into consideration the results derived from the expenditure would be unfair, as increased efficiency would certainly justify an added expense. There can be no paralleling the per capita cost of caring for the inmates of different institutions, one with another, and arriving at anything like true figures for any specific basis of expenditure for all institutions. If the per capita cost of an institution has increased, it is usually due to an increase in the value of articles used by the institution, and the only vital importance attached to this increase is a comparison of cost one year with another in the same institution, and increased wages now enter largely into this cost. In these times of reformers, economy is the slogan, and I know of too many hospital superintendents who are so busy laying plans for their future in the institution, that they have cut per capita cost until there is nothing left for wages, and when more money is requested by many of us we are continually referred to somebody's low per capita cost, and asked why we cannot get along on a like amount. When boards of control and the public realize that best results and efficient service necessitates the expenditure of goodly sums for wages, equipment and maintenance, then and only then will the state institutions be exemplifying the purpose for which they are created.

DR. WILGUS.—I will say just one word in closing. There has been no one here who has suggested that the state of affairs within the hospital precincts is satisfactory. In other words it is to be taken that things are not satisfactory, and the cause was dwelt on at some length in the paper. The cure for state hospital attendant troubles has been spoken of in many quarters as the development of the training school for nurses. I heard this 25 years ago after a training school for nurses had been started at my first hospital. Yet conditions in that hospital and in all other hospitals with training schools for that number of years failed to improve to the extent hoped for and expected by their initiators. I am not decrying the usefulness of the training schools in state hospitals, for they have done much good, but I believe we can say safely that they have failed to raise the standard of the state hospital service to the extent their early sponsors thought sure to come. Many state hospitals with services up to or above the average have no training schools, and in many institutions of good size we find but one or two or three graduates from the training school in a year and these not infrequently immediately leave the service for more remunerative fields. The idea of training schools, as suggested by my friend Doctor Kilbourne, was excellently conceived, but its promoters failed to take into consideration that the vast number of ward employees belong to that class mentioned in my paper, namely the class that neither by education nor by ambition desire for better things and are as unstable as the sands of the sea. The few that are benefited by the training school belong to that better type of which this paper speaks in laudatory terms and desires to have employed largely if not entirely to the exclusion of the other class. I have watched this sort of thing for nearly 25 years and am fully convinced that this plan will result in an entirely new grade of institution standards and that the plan is eminently practicable. The broad humane and economical principles involved in the attached Community Health Department are surely worth deep study and consideration.



## AN ANALYSIS OF THE ACCURACY OF PSYCHOPATHIC HOSPITAL DIAGNOSES.

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Studies of the outcome in psychiatric cases are obviously very important, especially where, as is true at the Psychopathic, diagnoses are based upon symptoms and the longitudinal section of the patient's life before admission. Only in a few cases do we have opportunity to see the final outcome and so check the diagnosis ourselves. The Kraepelinian conception of mental disease, to which we attempt to adhere, was largely founded upon a study of the terminus of pathological states. Accordingly, one important zone of psychiatric advance, for us at least, lies in a study of the outcome of the cases we see here.

The best method available to us for doing this is to follow those cases (about 60 per cent of our admissions) which are committed to the state institutions. This gives us information concerning outcome and also gives us an opinion independently formed; often, as can easily be shown, with diagnostic standards quite different from our own.

Accordingly, we have devised a follow-up scheme by which we secure from each institution its diagnosis and a brief note concerning the condition of the patient three months, six months and one year after commitment. Of course, in the organic cases and those already demented when seen by us, one note is usually sufficient unless there be disagreement in diagnosis. But in the active, acute cases, it is best to secure the full series. In this way conflicting diagnoses in the same case are sometimes given by the institution or institutions.

Advance in psychiatry can only come, as I have pointed out elsewhere,<sup>1</sup> if we carefully study the whole patient; make correct symptomatic diagnoses and then check such diagnoses against outcome. Furthermore, the real test of our diagnostic skill lies in applying such a rigorous system of inquiry regarding the further history of our patients. An additional value to such follow-up studies is that they reveal errors in working technique which need modification. They keep the workers keyed up to do the best possible work and tend to establish the habit of careful analysis. Furthermore, they show which groups of cases are most difficult of diagnosis; tend to establish causes for errors; lead to a wider co-operation and understanding between institutions; lead to more uniform standards of diagnoses. The application of uniform standards of diagnoses is really of much greater value than the selection of a uniform statistical grouping for patients.

Two previous studies of Psychopathic Hospital diagnoses have appeared. In 1914 Southard and Stearns<sup>2</sup> published a report dealing with the accuracy of Psychopathic Hospital Diagnoses in 1913. The study was carried out by following the patients committed from the Psychopathic Hospital to other state institutions and ascertaining the diagnosis of the institution to which the patient was sent. They found that about one case in five got no diagnosis at the Psychopathic, and that of those cases that had received a diagnosis, one in four had the diagnosis altered in the next state hospital. They found that a residuum of about 6 per cent remained unclassified. They considered that the most difficult field of diagnosis was shown to be that of dementia præcox and manic-depressive psychoses, and offered some abstracts of the more interesting individual patients. They were struck by the few changes made in the Psychopathic diagnosis of manic-depressive.

Recently the writer<sup>3</sup> has published a paper dealing with the accuracy of early diagnoses within the Psychopathic Hospital. This was done by checking the diagnosis in the admission office against the rounds, or staff meeting, or discharge diagnosis in the same patient. Of course this represents the checking of one diagnostic standard against itself and not against another standard, as is obtained when the Psychopathic Hospital diagnosis

is checked against the diagnosis of some other state institution. It is really a study in the accuracy of snap diagnoses in psychiatry, and it was shown that a high percentage of early diagnostic accuracy depends upon accurate observation, careful interpretation and sufficient information.

In this paper, data are presented dealing with the diagnoses in 419 cases committed to some state hospital, after a residence in the Psychopathic Hospital for from a few days to a month or more. The patients forming this group were committed during the period from November 1, 1916, to June 1, 1917, and were

TABLE I.  
THE ERRORS SHOWN BY HOSPITALS.  
(Omitting Psychopathic unclassified and undiagnosed.)

	Agree.	Disagree.	Total.	Per ct. error.
1. Boston .....	125	42	167	23.7
2. Worcester .....	67	17	84	20.2
3. Westboro.....	32	14	46	30.4
4. Taunton.....	21	4	25	16.0
5. Danvers.....	22	4	26	15.4
6. Medfield.....	9	4	13	30.7
7. Foxboro.....	2	1	3	....
8. Private.....	1	2	3	....
9. McLean.....	3	2	5	....
10. Northampton...	1	0	1	....
11. Grafton.....	15	0	15	0.0
12. Norfolk.....	1	1	2	....
13. Monson.....	6	0	6	....
Total.....	305	91	396	23.0%

reported on by the other institutions once, twice or three times. All cases with change in diagnosis were reported on at least twice in order to make sure whether the institution would change its diagnosis. So the group has been followed for from a year to a year and a half. I wish here to express our thanks to the superintendents of the various state hospitals who, by their reports, made this study possible.

Of the 419 patients, 23, or 5.5 per cent, received no definite diagnosis at the Psychopathic, *i. e.*, were left "unclassified"; leaving 396 patients receiving a definite diagnosis.

Table I shows for each institution the number of patients sent; the number in which the diagnosis agreed and the number in

which the diagnosis disagreed with the Psychopathic. The table shows that in 91, or 23 per cent, the diagnosis was changed, leaving 305 in which the diagnoses agreed. This figure is very near that found by Southard and Stearns.

In Table II are found by diagnosis and by institution the agreements in diagnosis so that an idea may be had of the type of cases sent to each institution.

TABLE II.  
TO SHOW THE AGREEMENTS IN DIAGNOSIS BY HOSPITALS.  
(Excluding unclassified.)

	Total.	1. Boston.	2. Worcester.	3. Westboro.	4. Taunton.	5. Danvers.	6. Medfield.	7. Foxboro.	8. Private.	9. McLean.	10. Northampton.	11. Grafton.	12. Norfolk.	13. Mendon.
Dementia Præcox .....	155	55 <sup>1</sup>	39	22	12	12	7	2	1	3 <sup>2</sup>	1	1	..	..
Manic-Depressive .....	42	24	5 <sup>3</sup>	5 <sup>4</sup>	2	5	..	..	..	..	..	1	..	..
Neurosyphilis .....	36	11	12	1	..	4	..	..	..	..	..	8	..	..
Ac. Alc. Psy .....	8	2 <sup>5</sup>	3 <sup>6</sup>	..	2	..	..	..	..	..	..	..	1	..
Chr. Alc. Psy .....	7	5 <sup>7</sup>	1	..	1	..	..	..	..	..	..	..	..	..
Senile Dementia .....	14	8	4	2	..	..	..	..	..	..	..	..	..	..
Epilepsy .....	12	..	1	..	..	..	..	..	..	..	..	5	..	6
Arteriosclerotic .....	12	7	..	1	2	1	1	..	..	..	..	..	..	..
Korsakow .....	7	5	1	..	1	..	..	..	..	..	..	..	..	..
Paranoid Condition ....	3	2	..	..	..	..	1	..	..	..	..	..	..	..
Post Puerperal .....	1	1	..	..	..	..	..	..	..	..	..	..	..	..
Psychoneurosis .....	1	..	..	1	..	..	..	..	..	..	..	..	..	..
Not Psychotic .....	7	5	1	..	1	..	..	..	..	..	..	..	..	..
Total .....	305	125	67	32	21	22	9	2	1	3	1	15	1	6

<sup>1</sup> One case first called manic-depressive, but on second inquiry the diagnosis agrees.

<sup>2</sup> One case first called presenile dementia, but on second inquiry the diagnosis agrees.

<sup>3</sup> Two cases first called dementia præcox, but on second inquiry the diagnosis agrees.

<sup>4</sup> One case first called dementia præcox, but on second inquiry the diagnosis agrees.

<sup>5</sup> One case first called dementia præcox, but on second inquiry the diagnosis agrees.

<sup>6</sup> One case first called psychopathic, but on second inquiry the diagnosis agrees.

<sup>7</sup> Four cases first called manic-depressive, and one infection-exhaustion psychosis, all eventually called dementia præcox.

Table III presents all of the data concerning diagnosis in readily accessible form. This shows, for each psychopathic diagnosis, the diagnoses made at the other institutions. The interesting features will be pointed out in the discussion below.

Table IV is a summary in which the results in all psychopathic groups having more than 10 cases are brought together. It will be seen that the error in dementia præcox is low, while the error in manic-depressive is high; this in contrast to the findings of Southard and Stearns. In certain smaller groups the error is



TABLE III.

## THE CHANGES IN DIAGNOSIS BETWEEN PSYCHOPATHIC AND STATE HOSPITALS.

The numbers at the tops of the columns correspond to the numbers assigned in the left-hand column to the Psychopathic Hospital diagnoses.

Psychopathic Hospital Diagnoses.	Other Hospitals Diagnoses.																				
	Total.	D. P.	M. D.	N. sy.	A. A. P.	Chr. A.	S. D.	Ep.	Art.	Kors.	Par.	Uncl.	Post P.	N. P.	Pre. S.	I. E.	16. Neur.	17. P. + F. M.	18. O. D.	19. Psy.	20. Inv. Mel.
1. Dementia Praecox.....	183	155	14	1	1	1	1	1	1	1	2	4	1	4	1	1	1	1	1	1	1
2. Manic-Depressive.....	60	11	42	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3. Neurosyphilis.....	39	2	36	1	8	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
4. Acute Alcoholic Psychoses.....	12	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
5. Chronic Alcoholic Psychoses.....	10	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
6. Senile Dementia.....	18	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
7. Epilepsy.....	12	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
8. Arteriosclerotic Psychoses.....	22	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
9. Korsakow's Syndrome.....	11	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
10. Paranoia and Uncl. Paranoid States	9	6	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
11. Unclassified.....	23	6	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
12. Postperpetual Psychosis.....	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
13. Not Psychotic.....	9	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
14. Presenile Psychosis.....	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
15. Toxic-Exhaustion.....	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
16. Neurasthenic Psychosis.....	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
17. Psychosis + Feeble-Minded.....	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
18. Organic Dementia.....	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
19. Psychoneurosis.....	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
20. Involution Melancholia.....	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
21. Symptomatic Psychosis.....	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
22. Chronic Toxic Psychosis.....	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
23. Traumatic Psychosis.....	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
24. Senile Delusional Psychosis.....	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Total.....	419	183	63	36	12	12	19	12	19	7	7	14	1	16	0	6	1	2	6	1	2

<sup>1</sup> A psychopathic "lucetic paranoid" is called "G. P. + paranoid D. P." <sup>2</sup> Called "chronic alcoholic psychosis" at psychopathic.

<sup>3</sup> Including three unclassified paranoid, one paraphrenia and two paranoia Psychopathic diagnoses.

also high, as in the acute alcoholic psychoses and in the arteriosclerotics. These figures, however, are less valuable because of the small number of cases concerned, but perhaps indicate an overstressing of certain symptoms or symptom-complexes in the diagnosis of these conditions.

The data presented in these tables are most conveniently discussed according to the psychiatric groups involved. The points of major interest are found in the cases with change in diagnosis. Accordingly, the greater stress is laid on these. In each case with recorded error, I have analyzed the Psychopathic Hospital record and have based a *personal opinion* as to diagnosis on that. Where-

TABLE IV.  
SUMMARY BY DIAGNOSES.  
(Arranged in Order of Diagnostic Accuracy).

	Psychopathic Hospital Diagnosis.	OTHER INSTITUTIONS.		
		Agree.	Disagree.	Per Cent. Disagree.
1. Epilepsy .....	12	12	0	0.0
2. Neurosyphilis .....	39	36	3	7.7
3. Dementia Præcox ....	183	155	28	14.8
4. Senile Dementia. ....	18	14	4	22.3
5. Manic-Depressive ....	60	42	18	30.0
6. Chr. Alc. Psychosis...	10	7	3	30.0
7. Acute Alc. Psychosis...	12	8	4	33.3
8. Korsakow.....	11	7	4	36.4
9. Arteriosclerotic .....	22	12	10	45.5

ever possible, I have also either seen the patient or the record from the other institution. This, however, has only been feasible with those patients committed to the Boston State Hospital, representing less than half of the number of errors. I have tried to make an impartial analysis and an unbiased criticism in these cases, with the aim of locating the causes for error if possible.

*Group I.*—Dementia Præcox: This diagnosis, made 183 times at the Psychopathic, was concurred with in 155 cases and disagreed with in 28. This amounts to an error in 14.8 per cent of cases—well below the error previously recorded. In 28 additional cases another Psychopathic diagnosis was changed to dementia præcox. So, if we incorrectly call 15 per cent of cases dementia præcox, and miss 15 per cent. our error becomes

rather high. Of course the last error is somewhat less serious than the first, since the chances are that a better prognosis was given with a non-dementia-præcox diagnosis.

Of the 28 "errors," four have been left "unclassified" by the institution to which they were sent, leaving 24 cases in which the diagnosis seemed erroneous.

Of these, 14 are called manic-depressive and two are in hospital "unimproved"; two in hospital "improved"; one was discharged "improved" and nine were discharged "recovered." It may be noted that one case was discharged as a recovered manic-depressive, only to be returned to the institution when a diagnosis of dementia præcox was made. This is, of course, not counted as an error. In six cases the first diagnosis returned from the other institution was something other than dementia præcox, usually manic-depressive, but on second or third inquiry the diagnosis was changed to dementia præcox. These cases again are not counted as errors. It is possible that of the four cases now in hospital, a few may yet be called dementia præcox.

In examining our records on these cases, I find that in three the record seems to me typical for manic-depressive, yet a diagnosis of dementia præcox was made. So far as I can see the misleading symptoms do not appear in the record, however clearly they may have appeared in the patient. In two additional cases I cannot form an opinion from our records, as they do not give a sufficiently clear analysis of the case. Neither case was hallucinated, but both were called "indifferent."

In two cases I should judge from the history and examination that neither diagnosis was entirely correct, since one case was post-puerperal and one post-operative. The post-partum case, in particular, seems to be one of the toxic exhaustion cases with recovery. The other case presented ideas of reference for a year before the sudden onset of an excited, hallucinated, deluded state following etherization. Here, the confusion and hallucinations, with later recovery, point more to a toxic psychosis than to dementia præcox or manic-depressive.

The remaining seven cases are of some interest and may be briefly abstracted:

CASE 1.—A man, age 44, first attack of mental trouble. Always rather seclusive, he suddenly became destructive, with ideas of electricity, chok-

ing, visual and olfactory hallucinations. He was depressed, emotional, self-accusatory, had many somatic and sex ideas, ideas of influence and hallucinations for several days. Remained oriented. Except for the hallucinosis he seemed to be a case of manic-depressive. We called him *dementia præcox*. Six weeks later he had been discharged "recovered." Here the hallucinatory episode was allowed too much weight in the diagnosis.

CASE 2.—This unusual case is so complex that I am not satisfied that either diagnosis is correct. In 1913 he was committed, a diagnosis of manic-depressive made and he was discharged "recovered." In 1915 he was at this hospital; provisional diagnosis—*dementia præcox*, determined—delirium tremens. In 1916 he was twice here with a diagnosis of acute alcoholic hallucinosis. In November, 1916, he was admitted for the third time that year. He had many fantastic delusions and numerous hallucinations. At our staff meeting, five preferred *dementia præcox* to manic-depressive; two, manic-depressive; three, alcoholic psychosis; two, unclassified. Committed to another hospital, a diagnosis of manic-depressive was made and he was discharged "recovered." His drinking may have been due to his manic-depressive attack, but it seems that his psychosis was markedly colored by the alcohol.

CASE 3.—At 39 this woman had an attack in which she was violent, fearful, self-accusatory and called the dead. This lasted for four months. At 40 she had a similar attack of two weeks' duration; again at 42. At 43 she had an attack of four months' duration, this time influenced by alcohol. She was described as normal between attacks. At 44 she was admitted with auditory and visual hallucinations and ideas of electrical influence. There was no intelligence defect. She was indifferent; at first disturbed, then quiet, inaccessible, mute, resistive and had to be tube fed. During a month this condition continued. After transfer she was discharged as recovered from a manic-depressive attack.

If we grant that the observations were correct, and there was no history of alcohol, then our diagnosis was symptomatically correct; although the history would indicate a good prognosis for the attack.

CASE 4.—The mother of this girl developed a paranoid psychosis at about 55. The patient was disappointed in love; then became suspicious, deluded and worried. She became hallucinated, with conduct disorder based on this. She was frightened, agitated, depressed, resistive, hallucinated, suspicious, mute, deluded. She was impulsive, at times excited. This continued through her stay of two weeks. After transfer she was discharged as a recovered manic-depressive.

With the exception of the rather normal emotional response to the ideas and hallucinations, our diagnosis would seem to be symptomatically correct, but not verified by outcome.

CASE 5.—An interesting case of "late katatonia" occurring in a man of 50, with mental changes for a year and a previous attack with hallucinations. He was hallucinated and showed *cerea flexibilitas*, with later recovery.

CASE 6.—In this man the question of manic-depressive-mixed might be raised. He had gradually changed through three years and when seen at 38 was indifferent, irritable, deluded, hallucinated, impulsive, self-accusatory and somewhat depressed. In about three months was discharged "improved" and is now recorded as "recovered."

CASE 7.—This patient at 29 had an attack in which no hallucinations were demonstrable, but she was disturbed and later mute and resistive. She continued to show many queer signs but has now a "well-connected depression in which there seems to be nothing schizophrenic." Hence, she is regarded as a case of manic-depressive.

The next important group in which the diagnosis was changed is the group of four cases called "not psychotic." Two of these were called "constitutional inferiority" and two were called "feeble-minded." There is no doubt of this groundwork for the mental state in all four cases, but the symptom analysis of the four certainly shows a pathological mental state hardly to be explained by just this diagnosis. I am not arguing that they were necessarily cases of dementia præcox, but that there was something added. That the committing physicians who visit this hospital are very cautious about committing cases on such grounds alone is an additional point in favor of the view that there was a psychotic state. At all events, it is perfectly clear that episodes of various types occur in such patients, but it is not perfectly clear whether they are always a part of the original state or represent a new process.

One case in particular, studied by us for more than a month and twice presented at staff meeting, was called an imbecile at the hospital to which he went, although because of agrammatisms, neologisms and what might be called neograms and certain other schizophrenic features, we had made a diagnosis of dementia præcox which evidently went back for a considerable distance into his youth. There was a possibility of an organic condition. Accordingly, one would hardly be satisfied with the simple diagnosis of imbecility in a complex case of this type.

One case was called delirium tremens, but is still in the hospital a year and a half after commitment, where he is regarded as improved and is working steadily in the kitchen. If it were really a simple case of delirium tremens one would hardly expect that he would spend a year in a hospital. Our record says there is no alcoholic history, that he was apathetic, had ideas of persecution

and somatic delusions. He was not at any time confused. All of these are points against the diagnosis of delirium tremens.

One case which we called dementia præcox with senile changes was called senile dementia. He was 68, had been at Worcester at 18, at the Boston State Hospital at 30 and in some other asylum at 40. For many years, at least 12, he had been foolish, had ideas of persecution, confusion of recent memory, was pleasant, quiet and there were probably auditory hallucinations. The correct diagnosis would depend upon the accuracy of the history of changes for many years.

Two cases called by us paranoid dementia præcox were called unclassified paranoid condition. For the discussion of the difficulties in the way of diagnosis in the paranoid group, see below under "Unclassified Paranoids."

One case was called a toxic exhaustion psychosis from morphine and this diagnosis seems to have been correct, although we got no history of any morphine use.

One case was a post-puerperal case occurring in a negro girl, but with all the characteristics of dementia præcox. However, the institution to which she was sent made a diagnosis of psychosis plus feeble-mindedness and regarded her not as deteriorated but as having been originally of low level. Of course, the diagnosis psychosis plus feeble-mindedness is really equivalent to "undiagnosed" or "unclassified," since it does not attempt to state the type of psychosis present.

*Group II.—Manic-Depressive:* In this group there were proportionally many more changes than in the dementia præcox group. Our diagnosis was changed in 18, or 30 per cent of the group. In addition, 21 cases called something else by us were finally diagnosed manic-depressive by the other institutions.

The most interesting change is that from manic-depressive to dementia præcox, made in 11 cases. Two cases were discharged from the hospital making the diagnosis dementia præcox, as "recovered"; one was discharged as "improved." In all three cases the history of previous attacks or the examination here indicates manic-depressive to me.

One case has died and our record is to me clearly that of a paranoid dementia præcox and not manic-depressive as we diagnosed it.

The other seven cases remain in hospital "unimproved." Of these, one was called by us "chronic mania," which is probably really dementia præcox with long-continued excitement. Three cases I should call dementia præcox from reading the Psychopathic Hospital record. One case has an involution psychosis with uncertain features. One case is clearly a manic-depressive with three attacks, a complete recovery between each, and typical symptoms of manic-depressive, manic. The last case had a previous attack with recovery, then a second attack at 41. There were certain slight changes in the spinal fluid, indicating a probable organic disease. There were some symptoms of a præcox type, but the question of organic brain disease cannot be easily ruled out.

Accordingly, we can summarize the manic-depressive to dementia præcox changes by saying that in four cases the changes in diagnosis may be seriously doubted for reasons given above; one case is a chronic mania, which is probably dementia præcox; that four cases appear to be dementia præcox from the Psychopathic Hospital records and in the other two cases the change in diagnosis may be questioned, but it is possibly correct.

One case of agitated depression at the involution period was called a post-operative psychosis, despite the absence of consciousness, disorder and hallucinations and a persistence of the process for two years. In this case I should certainly believe involutional melancholia to be the proper diagnosis.

A case with three attacks of manic-depressive psychosis spent two of them at the same hospital which finally diagnosed his case alcoholic dementia, despite the rather typical manic picture shown.

Another very interesting manic case, with unusual features pointing to præcox, was called an alcoholic psychosis, despite the fact that our rather elaborate study of the case for three weeks failed to reveal more than a minimal use of alcohol. The symptoms were chiefly those of mania.

A hypomanic case was called a defective delinquent. To be sure, the boy was both defective and delinquent, but at the time of commitment he was certainly hypomanic. It may be noted that the diagnosis "defective delinquent" needs to be handled with care. Such patients may also be, or become, insane—a fact frequently overlooked. From the same institution I have recently obtained a diagnosis of defective delinquent in a straight out-and-

out paranoid case that has been committed three times to state hospitals.

One case of depression was called a neurasthenic psychosis. With this diagnosis I have no quarrel to make, since, as I have recently pointed out, the differential diagnosis between psychosis and psychoneurosis is often extremely difficult to make and, furthermore, many so called psychoneurotics are really insane in the technical sense of the word.

*Group III.*—Neurosyphilis: One would not expect to find any diagnostic errors in this group, except within the group itself (*i. e.*, cases diagnosticated paresis turn out vascular lues, etc.) because of the exact laboratory methods which are available for aid in diagnosis. However, there is a group of cases in which we find a psychosis, or even no psychosis, plus the serology of neurosyphilis, the latter producing no symptoms which can be directly attributed to it. Such cases have been reported in considerable numbers (see Barrett,<sup>1</sup> Lowrey,<sup>2,3,4</sup> Southard & Solomon,<sup>5,6</sup>) and several more such cases could now be added to the list.

Of the three errors in diagnoses which appear in our table only one, the case called alcoholic dementia, is of this type. This case was diagnosed "chronic alcoholic psychosis+neurosyphilis" at the Psychopathic, from which it will be seen that the major importance of alcohol was recognized, but the presence of neurosyphilis was also indicated. The two cases called dementia præcox by other hospitals are clearly, from our records, dementia præcox and there is no serological evidence to back up a diagnosis of neurosyphilis and I do not understand how such a diagnosis was made. A final case, which I have not classed as an error, was called "luectic paranoid" at the Psychopathic and "general paresis +paranoid dementia præcox" at the other hospital. I should feel that our diagnosis was probably more logical. At any rate, I should want some extremely good evidence of the existence of the usual symptoms of paresis before I made a double diagnosis. However, both diagnoses recognized the relationship: neurosyphilis+paranoid psychosis.

*Group IV.*—Acute Alcoholic Psychosis: Of the four errors in this group of 12, one in which we raised a question of dementia præcox has been discharged as self-supporting, although some-



what dull. Another case called manic-depressive, manic, is said to show blunting, probably due to the use of alcohol. One case called by us alcoholic hallucinosis has been discharged recovered from a toxic insanity. Of course alcoholic hallucinosis is a toxic psychosis, but is a more exact diagnosis than merely *toxic*. Another patient called by us alcoholic hallucinosis has been discharged as a recovered case of dementia præcox. We are all aware that in a typical case of alcoholic hallucinosis, the differential diagnosis is alcoholic hallucinosis versus paranoid dementia præcox. The differentiation is to be based upon three factors: 1, The history of the abuse of alcohol in a person who was previously regarded as normal; 2, the normal emotional response to the ideas and hallucinations entertained; 3, the outcome in recovery in from four to six weeks, with good insight into the past mental illness. Accordingly, I should suspect that in two, and perhaps three of these cases the Psychopathic diagnosis was more nearly correct, judging by the history, symptoms and outcome, than the diagnosis in the other institutions.

*Group V.*—In the chronic alcoholic group, the two cases in which the diagnosis was changed to "not psychotic" did not present enough deterioration at the Psychopathic Hospital to be committed as insane, but were sent to the institutions as "habitual drunkards." So that, although I have classed them as errors in the table, they are really not such, since in both cases the other institution makes a diagnosis of "inebriate." The third case, however, is a rather interesting one of aphasia, in which the other hospital diagnosis of arteriosclerosis seems to be correct.

*Group VI.*—Senile Group: One case was diagnosed as an organic dementia which really amounts to saying that there is dementia due to some type of organic disease. It does not, however, make any exact diagnosis of the organic disturbance. A second case was called manic-depressive psychosis, apparently due to some history which we had not obtained. In a third case the diagnosis was changed to cerebral arteriosclerosis. Of course the differential diagnosis between senile dementia and arteriosclerotic psychosis is not always easy and in many cases represents a question of evaluation of indirect evidence more than anything else. One interesting case, which we called a senile

psychosis, was discharged "improved" with a diagnosis of "not insane" from the hospital to which she was sent. This woman's daughter, who was about 40 years of age, had a marked paranoid psychosis of slow development. The two women lived alone and the daughter convinced the mother of the reality of her delusions and hallucinations, and the old lady firmly believed them. We called it a senile psychosis although she was not demented.

*Group VII.—Epilepsy:* There were no disagreements in the diagnosis of epilepsy and we missed no diagnoses of epilepsy. This is probably to be explained by the fact that the epileptic cases which we see have usually a long history of fits or perhaps have some while they are in the institution. There has not always been verbal agreement as to the diagnosis of epileptic psychosis, but that of course may be due to a clearing up of the psychotic state at about the time of discharge to the other institution.

*Group VIII.—Arteriosclerotic Psychoses:* On the surface it appears that our least accuracy in diagnosis lies in the field of the arteriosclerotic psychoses. The diagnoses returned by the other institutions concurred with us in only 12 of 22 cases and in addition seven cases called by us something else are called arteriosclerosis by the institutions.

Three cases were called senile dementia. As was pointed out above, this differentiation is often very difficult to make, especially in the more advanced cases, and it often represents an interpretation of certain equivocal signs and an evaluation of conditions which can only be indirectly estimated. Accordingly, although these diagnoses are erroneous, the error is perhaps not a particularly serious one.

Two patients were called organic dementia, just as a case diagnosed by us "organic dementia" was called "cerebral arteriosclerosis" in the other institution. Of course, as pointed out above, organic dementia is not a diagnosis in the ordinary sense of that word, it is merely a recognition of state and a partial putting together of symptoms. Another case is regarded as one of chronic alcoholic psychosis. Here again the major symptomatology is much the same in the two conditions and differentiation depends upon history and the evaluation of certain signs. In this case there is an alcoholic history, but there are also signs of cerebral arteriosclerosis. Another case was left "unclassified,"

between alcoholic dementia and cerebral tumor, and here from our records the diagnosis would seem to be arteriosclerosis.

Three cases were called manic-depressive. Of these, one is clearly, from our records, a case of arteriosclerotic dementia and she has apparently an early stage of chorea. Had the chorea come on somewhat earlier in the course and been more marked, we should have been tempted to call her a case of "degenerative chorea." There are no evident signs of manic-depressive. To be sure she has periods of depression and excitement, never long continued, amounting really to an emotional instability. In the other two cases the portion of the symptomatology which is unusual for manic-depressive lies in the periods of confusions. Aside from this, one case might well be regarded as a manic-depressive-mixed and the other as a manic-depressive-depressed.

*Group IX.*—Korsakow's: This syndrome is one which has very definite signs and one in which we should not expect the diagnosis to be in error. However, there were four cases in which we seem to have made an erroneous diagnosis. One of these was called alcoholic dementia. It is well known that the outcome of a Korsakow's attack is often dementia and this dementia is usually very marked. Accordingly, in this case we are probably both right in the diagnosis. A second case recovered from a "toxic psychosis," which, of course, Korsakow's syndrome is. A third case was discharged as recovered from alcoholic hallucinosis. There were here certain slight signs of neuritis and some confusion which allowed us to believe that it was an early phase of Korsakow's. Apparently, however, the damage was not so great and the case ran the course of an hallucinosis. The fourth case was a very interesting one in which we were none too sure of the diagnosis, "Korsakow's," but we were unable, after an exhaustive study for more than a month, to reach any other conclusion. He has been left "unclassified" and is improving.

*Group X.*—The paranoid conditions constitute one of the most difficult groups in which to make a differential diagnosis. The tendency has been to classify the hallucinated paranoid conditions as paranoid dementia præcox, reserving the term "paranoia" for those cases of very long and slow evolution, in which there is a

well-systematized set of paranoid ideas without hallucinations and without deterioration. We made the diagnosis of paranoid in only two cases. In each case the state institutions made a diagnosis of paranoid dementia præcox, which I believe to be correct in one and probably incorrect in the other.

According to Kraepelin's last edition only about 40 per cent of the paranoid conditions with progressive delusion formation, not due to syphilis or alcohol, are cases of dementia præcox. The deterioration is often very slow in developing in these cases. About 50 to 55 per cent of the paranoid group as limited are cases of paraphrenia, while the remaining small percentage are cases of true paranoia.

We attempt now to differentiate the paranoid præcox group from the other paranoid cases by insisting that they show the characteristic emotion and will difficulties of schizophrenia. If they do not show these signs we usually leave them in the unclassified paranoid group. In one case we made a diagnosis of paraphrenia confabulans, which was changed to dementia præcox paranoid. This and two other changes from unclassified paranoid to dementia præcox represent really differences in standards of diagnosis and not any particular differences in the conception of the case. The final case, however, was a very interesting legal case in which we were not able certainly to determine the presence of hallucinations or to show any very marked deterioration. We felt that she was probably a paranoid præcox, but thought it safer to leave the case unclassified paranoid. Since being at the other hospital she has shown very clearly the characteristics of paranoid dementia præcox.

*Group XI.*—Unclassified: Concerning this group I have very little to say. They represent the cases in which for one reason or another we were not able definitely to decide what the psychosis was, during the period of observation here. They present, of course, a good many problems, as do all unclassified cases. In 18 of the 23 the other institutions were able to classify them but the institutions added, to the residue of five, eight more cases which they could not classify.

The remaining changes in diagnosis need not be discussed at very great length. They represent for the most part differences

in standards of diagnoses. Under the "not psychotic group" are included cases of feeble-mindedness and of psychopathic personality, which had for one reason or another to be committed. They all have a mental disease although it is not perhaps in the form of a psychosis. The scattering of further changes is not particularly important.

#### SUMMARY.

Data are presented dealing with the accuracy of the Psychopathic Hospital diagnoses on 419 patients. The Psychopathic diagnosis was determined within 10 days in all but a few. In a few cases we had more time, up to a month, to study the case. The cases have been followed for a year to a year and a half.

The figures are based upon the diagnoses made at 11 state institutions, McLean Hospital, and a small group of private sanatoria, to which our patients were committed. Most cases have been reported twice, and in a few instances three times.

The general error in diagnosis is established at 23.0 per cent (omitting the unclassified cases from consideration).

This error is not evenly distributed. Our greatest accuracy is in epilepsy (100 per cent); next in neurosyphilis (92.3 per cent); then dementia præcox (85.2 per cent.) Of the larger groups we are least accurate in arteriosclerotic psychosis (54.5 per cent); then in Korsakow's (63.6 per cent); then the acute alcoholic psychoses (66.6 per cent); then manic-depressive and chronic alcohol psychoses (70 per cent).

Many cases have had more than one diagnosis from the other institutions.

We diagnosed dementia præcox in 183 cases: diagnosis changed in 28, of which four were left unclassified. Twenty-eight cases were added to this group.

Of the 24 definite changes, two were unclassified paranoid. In three cases our record seems clearly that of a manic-depressive; in one, manic-depressive+some unusual symptoms. In these four cases there should have been no error. One case of late katatonia should probably not be called manic-depressive. In three cases, our record is that of dementia præcox, and the outcome is not yet certain. In four cases our diagnosis seems symp-

tomatically correct, but not verified by outcome. In three cases I believe neither diagnosis to be correct, and in four more I am fairly certain the final diagnosis is incorrect, but have no exact opinion as to correct diagnosis. In another case the accuracy of the history must decide: in two, I can form no opinion.

The diagnosis was changed in 18 of 60 cases called manic-depressive at the Psychopathic, and 21 cases were added. One case is left unclassified.

Of the 17 definite changes, my own opinion is as follows: That in eight cases, according to symptomatology and outcome, the Psychopathic diagnosis is probably correct; in four cases the Psychopathic record is such that a diagnosis of manic-depressive should not have been made, and the other institution is correct; in three, the second diagnosis is probably correct, although the Psychopathic diagnosis may eventually be proven.

Of the three errors made in the diagnosis of 39 cases of neurosyphilis, two should not have been made, since our record clearly agrees with the other institution's diagnosis. In the third case we recognized the presence of neurosyphilis, which the other institution did not.

Of the four errors in the diagnosis of 12 cases of the acute alcoholic group, I should doubt the "recovered" dementia præcox; believe that acute alcoholic hallucinosis is a better diagnosis than "toxic insanity"; and believe that a recovered manic-depressive showing "blunting due to the use of alcohol" *probably* had an alcoholic psychosis.

Two of the three errors in the chronic alcoholic group are really not errors, since we did not regard them as sufficiently deteriorated to commit as insane. The other case is a frank error.

In the arteriosclerotic group, changes to senile dementia occur three times. Such changes depend largely upon interpretation of findings. In four of the 10 cases in which diagnosis was changed, the second diagnosis seems to be erroneous, and in two more the diagnosis is less exact than ours, while one case is left unclassified.

The four changes in the diagnosis of Korsakow's syndrome represent: 1, A very difficult case in which we were none too sure of the diagnosis; 2, an end state (dementia); 3, a "toxic" psychosis; 4, alcoholic hallucinosis.

The paranoid conditions are often very difficult of exact diagnosis. Four of the six changes represent differences in diagnostic ideas; one more was caused by further developments in the course of the disease.

Therefore, in 396 cases diagnosticated, there were 91 changes. Of these nine are left unclassified, and the Psychopathic diagnosis may eventually be proven correct. Of the remaining 82, 10 are cases in which, from the Psychopathic record, no error should have been made. In 21 more the Psychopathic diagnosis is probably correct. Three cases classed as errors are not really so. In three cases probably neither diagnosis is correct. So, if we exclude the cases left unclassified; the cases in which we are probably correct and those in which there was really no error, we are left with a total of 58 frank errors among 396 cases, or 14.6 per cent. This raises the question: "What is the error in psychiatric diagnosis at large?" which can only be answered by each institution critically analyzing its own diagnoses and errors. Compilation of such figures from several institutions would be of extreme value.

It appears more and more strongly that *accurate observation and intelligent interpretation* are the fundamentals of correct diagnosis, and that there is need of a unification of diagnostic standards.

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## MEMORIAL NOTICES.

JOHN B. CHAPIN, M. D., LL. D.

"Formed on the good old plan,  
A true and brave and downright honest man.  
Loathing pretence, he did with cheerful will  
What others talked of, while their hands were still."

In the fullness of years, in quiet retirement after more than a half-century's active professional toil, amid scenes endeared to him by early years of association and work, surrounded by his children, having the admiration and love of the members of his profession and the affectionate gratitude of unnumbered persons to whom or to whose friends he had been physician, guide, counsellor and friend, Dr. Chapin died at his home in Canandaigua, N. Y., on January 17, 1918.

"Life's work well done,  
Life's race well run,  
Then comes rest."

And here one might pause. Dr. Chapin's whole life had been lived in the open, his record has been made in the history of his state in the annals of the hospitals with which he has been connected, in the printed page, but more clearly in the hearts of his friends, lay and professional, and nothing that we can here set down will augment his fame. The question however confronts us: "Because he needs no praise, wilt thou be dumb?" We may not so excuse silence much as we doubt our ability to adequately meet the task of writing something which shall in a small measure portray his career, and record our own affectionate regard, our profound sense of bereavement, as well as that of his professional friends and associates.

Dr. Chapin descends on the one side from Puritan ancestors, being in the eighth generation from Samuel Chapin, one of the founders of Springfield, Massachusetts, who is commemorated by St. Gaudens' beautiful statue in that city. Samuel Chapin, the son of John Chapin, was christened in the parish of Paignton, Devonshire, England, in 1598. He took the freeman's oath in Boston, June 2, 1641. He was a magistrate, a deacon in the church, and

much employed in public affairs. His descendants appear to have followed in his footsteps. Dr. Chapin's great-grandfather was a soldier in the colonial wars and in the War of the Revolution.

In some memoranda which Dr. Chapin has left he says, "There is a pride, perhaps pardonable, in tracing a lineage through a long line of ancestors who in their day revered God, stood for their principles as of more value than earthly riches or titles, who valued good citizenship and their simple lives."

Dr. Chapin's father, William, was the son of Nathan Chapin who removed from Springfield to Philadelphia and who married Elizabeth Castner, a descendant of a German Quaker, one of a company of immigrants who became identified with the Society of Friends of Gwynedd, Montgomery Co., Pennsylvania.

William Chapin was born in 1802. He was a man of artistic tastes and literary ability, and acquired a practical knowledge of the art of steel engraving which he applied to the production and publication of maps in New York City. He was also a contributor to the periodical press.

He early became interested in the blind and in 1840 became the superintendent of the Ohio Institution for the Blind at Columbus, Ohio. The education of the blind became his life work and some years afterward, during his son John's first year in college, he was called to the principalship of the Pennsylvania Institution for the Instruction of the Blind, in Philadelphia, where he remained until compelled to relinquish the duties of the position by the infirmities of age.

Dr. Chapin's pardonable pride in his long line of ancestors to which we have referred was not based alone on the records of the paternal side. His mother was Elizabeth H. Bassett, daughter of Rev. John Bassett, D. D., a graduate of Columbia College, the recipient of honorary degrees from Williams College, Yale College and Columbia University; minister of the Reformed Churches at Albany, N. Y., and at Bushwick, Long Island, N. Y., and Kingston, N. Y. The Rev. John Bassett's ancestors were Harmen Thomas Hun, born in Amersfort, Holland, who settled in Albany in 1661, and Francois Bassett, a mariner, who was born in Marcimes, France, and who with other Huguenots arrived as fugitives from France in Boston in 1664 and was a resident of New York in 1685. His son Francis was a governor of the New

York Hospital, a charter member, named in the Royal Charter granted in 1771. In this hospital, his great grandson, Dr. Chapin, served as interne and then as resident physician.

Dr. Chapin was born in New York, on December 4, 1829. When he was about two years of age, the family removed to the vicinity of Penn Yan in Yates Co., N. Y., and there, when he arrived at the proper age, his education began in a country school-house which he has described as a room about sixteen by eighteen feet in dimensions with a sloping shelf attached to the wall for use as a desk with benches or sittings so placed that the pupils faced the wall and the inclined shelf or desk. The teacher sat in the center of the room near the stove. From this school he went to an academy in Penn Yan, but the arbitrary discipline of the teacher was such that he soon left the school.

The years passed in Yates County, the experiences of farm life and all the associations of an impressionable period had a lasting influence upon Dr. Chapin's career.

In 1840 his father, as has been stated, removed to Columbus, Ohio, to assume the direction of the institution for the blind in that city. The journey was made by stage-coach and canal-boat to Buffalo, and thence by lake to Cleveland, Ohio, and by canal-boat again to Columbus, the journey being accomplished in 12 days.

The educational opportunities at Columbus not being satisfactory, it was decided in March, 1844, that he was to be sent to Philadelphia to enter the public schools of that city, and the young lad set off alone by stage-coach, travelling night and day until Harper's Ferry was reached, whence he proceeded by rail to Baltimore and thence to Philadelphia in the same manner.

In Philadelphia he found a home in the family of a friend of his father's and entered the northwest grammar school, where in a short time he was by reason of his high standing offered an opportunity to enter the high school, which however he did not accept. His father had given him letters to different friends in the city, among them one to Dr. Thomas S. Kirkbride, which in due time he presented, thus meeting the man whom he was to succeed as the medical chief of the Department for the Insane of the Pennsylvania Hospital, forty years thereafter. After about a year in Philadelphia, Dr. Chapin returned to Columbus and entered upon

a preparation for a college course at Hudson, Ohio, entering the Western Reserve College in 1846.

His father having removed to Philadelphia, it was decided that the son John should enter Williams College in his sophomore year, and from that institution he received the degree of A. B. in 1850.

While at Williams he had the advantage of contact with that famous educator, President Mark Hopkins. Many of his classmates attained eminence in various fields. Two became college presidents, others attained distinction as judges of courts, clergymen, members of the bar, physicians, and in the military service of the United States in the Civil War.

Early in his student days, Dr. Chapin decided to enter the medical profession, and while in college and during vacations he read several medical books, during one winter joined an anatomical class and attended lectures on the subject. He was aided and in some measure directed in his medical studies by Dr. Charles Hubbell of Williamstown, who invited him to ride with him to see patients, and occasionally to assist him.

On the first of September, 1850, arrangements were made, in conformity to the custom at that time, and for a long time thereafter in vogue, for him to enter the office of Dr. John A. Swett, one of the attending physicians to the New York Hospital, as a student of medicine.

Soon afterward he obtained a substitute internship in the hospital and in 1852, after passing an examination, an appointment on the house staff. During this period he had attended, by permission of the governors of the hospital, medical lectures at the Jefferson Medical College in Philadelphia, from which he received the degree of M. D., in 1853. In 1854 he was made house physician in the New York Hospital after more than two years' service in junior grades. The hospital was then located on Broadway, opposite Pearl street.

Here he had a very active service. Cholera and typhus fever were epidemic in New York during his service in the hospital, and it became necessary to erect temporary pavilions on the hospital grounds. In April, 1852, while an interne at the hospital, he attended the seventh annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, now the American Medico-Psychological Association.

In a telegram sent to the Association in May last at its meeting in New York, in response to a telegram of congratulation on completing fifty years of membership in the Association Dr. Chapin said, "What changes in the care of the insane I have witnessed since my first visit to its New York meeting in 1852 as a visitor, which first inclined my mind to enter its service." During his residence in the New York Hospital he also paid several visits to the Bloomingdale Asylum, the department of the hospital for the insane. The clinical opportunities afforded at the hospital were highly appreciated by the young student. Many conditions now rarely observed were presented for treatment. Cholera and typhus fever have already been mentioned. In addition yellow fever was not infrequently seen, and "during a single month in the summer of 1852 more than three hundred cases of malarious disease (so-called) were received in the medical wards." Sailors with diseases of the tropics; immigrants, many of them from Ireland, where famine prevailed, crowding the ships sailing to America, arriving after long, tedious voyages, in unsanitary vessels, added to the work of the hospital and to the variety of conditions presented for study.

Under such conditions it is not remarkable that many of the resident physicians in the hospitals in New York succumbed to diseases they contracted in the service. Dr. Chapin's zeal in following up some cases of diphtheria in a family stricken with it led to his contracting a severe attack of the disease.

Completing his service in the hospital, with no predilection for private practice, permission was sought to appear for examination for entrance to the medical corps of the U. S. Army. While awaiting a reply to this request, an invitation was received from Dr. John P. Gray, medical superintendent of the New York State Lunatic Asylum, now the State Hospital, at Utica, to accept an appointment as assistant physician at that institution. This invitation was in direct line with Dr. Chapin's inclination and was accepted, and in September, 1854, he entered upon the duties of the position. Here he found problems confronting him quite different from those he had hitherto met. The lack of previous training in psychiatry was recognized, but the application of general medical training already attained successfully met the situation.

The *AMERICAN JOURNAL OF INSANITY* was edited and published at the asylum. Its printing at that time was done by patients under the direction of an employed printer of experience and in its editorial conduct, in connection with the medical superintendent, Dr. Chapin found congenial occupation. Here also he found an excellent medical library.

In 1854 the superintendents of the poor of the various counties of the state held a convention and appointed a committee to address a memorial to the state legislature asking for additional hospital provision for the insane confined in the county almshouses. Dr. Gray was present at the convention and vigorously supported the measure and proffered such assistance as he could render in carrying out the laudable desires of the members of the convention.

At Dr. Gray's request Dr. Chapin entered upon the work of procuring data as to the number of insane in the almshouses, and information as to their condition and the methods of care in vogue, and the preparation of the memorial to the legislature.

This memorial, the work almost wholly of Dr. Chapin, appears as Senate Document No. 17, January, 1856, New York State Legislature. Thus began Dr. Chapin's work for the better care of the chronic insane of New York, and the removal of all insane persons from the county almshouses, which culminated in the establishment of the Willard Asylum, now the Willard State Hospital, with which his name will be forever inseparably connected.

The Senate adopted a resolution appointing in February, 1856, a special committee to visit all almshouses, county homes, and charitable institutions in the state, and as a result of its investigations a bill was introduced the following year creating two additional asylums for the insane and an asylum for the reception of insane convicts and criminals.

The bill for the two additional asylums failed mainly because of selfish contentions as to their location, but a bill was passed creating an asylum for insane convicts and criminals within the grounds of the state prison at Auburn. During the year 1857 Dr. Chapin was assigned to the duty of examining the prisoners at Auburn, while Dr. E. H. Van Deusen, then a fellow-assistant physician at Utica, performed the same duty at Sing Sing and

Dannemora prisons. There were at the time 22 insane criminals at the Utica hospital.

About this time Dr. Gray proposed with the full approval of the managers of the hospital that Dr. Chapin be given an indefinite leave of absence with continuance of salary and a provision for necessary expenses, and instruments, to go to Paris and take up research work in neuropathology, especially as related to psychiatry, and in clinical psychiatry.

This was one of the earliest, if not the earliest, of plans in this country to promote special scientific study of mental disorders and their pathology.

A fire which occurred in July, 1857, at the Utica Asylum, destroying the administration building and part of one wing occupied by women patients, resulted in such a disturbed condition in the medical and administrative work at the institution that these plans were for the time abandoned.

It is interesting to conjecture what might have resulted for the good of psychiatry at the Utica asylum and in the community at large had they been carried out, and the marked change in Dr. Chapin's career which would have followed.

Clearly he had made in his three years of service at the hospital a most favorable impression upon his medical chief as well as upon the managers of the institution to have been selected for such work and promised such liberal support.

Dr. Chapin has recorded that during his service at the New York Hospital and at Utica he considered it a "first requisite to acquire knowledge of all the many details of institution work, with abiding confidence that it would become available somewhere at some time."

In the latter part of 1857 he resigned his position at Utica to take effect early in 1858, when his successor was appointed. He was succeeded by Dr. Joseph M. Cleaveland, afterwards medical superintendent of the state asylum at Poughkeepsie, N. Y.

When returning to Philadelphia, he called at Canandaigua, N. Y., upon Dr. George Cook, who had been an assistant physician at Utica under Dr. Brigham, and who after a year spent in foreign asylums, in 1854, returned for a year's further service at Utica in 1855.

Dr. Chapin had then no definite plans. He had thought of entering practice in either Philadelphia or New York, and the medical service of the army or navy had also been considered. He was met by a proposition from Dr. Cook to join him in the conduct of Brigham Hall, a small private hospital for mental disorders which Dr. Cook had established at Canandaigua in 1856.

It was agreed that the hospital was to be enlarged and incorporated. The act of incorporation was passed by the N. Y. State Legislature in 1859, incorporating "Brigham Hall—A Hospital for the Insane." The addition of a new wing was undertaken, with the expectation of having it and certain other improvements completed early in 1860.

In the meantime, having returned to Philadelphia, Dr. Chapin found that his father had been requested to name a suitable person to organize a new institution for the blind in St. Louis, Mo.

This position was accepted by Dr. Chapin, and on March 18, 1858, the day of his marriage to Miss Harriet E. Preston, he left for his new position. The position was accepted for temporary occupancy, as he had become committed to Dr. Cook and Brigham Hall, and in April, 1860, his connection with the St. Louis institution ended.

In May, 1860, he resumed his professional work with the insane, and his association with his friend and former associate at Utica, Dr. George Cook. During his residence in Canandaigua, Dr. Chapin formed many attachments, both personal and local, and his work and associates were most congenial, and to Canandaigua his mind turned as to a pleasant haven of rest, when he retired from hospital work in 1911.

After the convention of the superintendents of the poor of the counties, in 1854, and the action of the state legislature in 1856, which as has been seen came to naught, nothing was done to improve the condition of the insane in the almshouses, and their number steadily increased. There was no law preventing the direct commitment of the acute insane to almshouses, and patients supported by the counties in the single state hospital, at Utica, were removed to the almshouses as soon as their outlook became hopeless. and to make room for other cases.



Dr. Chapin never lost interest in these unfortunates, and when, in 1864, the State Medical Society inaugurated a movement in their behalf he entered heartily upon the work.

A resolution formulated by his associate Dr. Cook and Dr. Charles A. Lee called for a committee to confer with the legislature. This committee, Dr. Charles A. Lee, Dr. S. D. Willard, and Dr. George Cook, in conjunction with committees of the legislature, formulated a bill which became a law in April, 1864, directing the county judges to appoint a physician in each county to visit the almshouse and report upon its condition and that of the insane confined therein.

These reports were directed to be made to Dr. S. D. Willard, secretary of the State Society. From these reports much was learned. Dr. Chapin urged upon Dr. Willard the erection of an institution for the reception of these patients, and that the almshouses should no longer be legal receptacles for the insane, either acute or chronic.

Governor Fenton, in his message to the legislature in 1865, said among other things, "The propriety of establishing an institution for incurables, an institution that shall relieve county authorities from the care of the insane, should be deliberately considered."

A bill was drawn and passed on April 6, 1865, creating the new asylum, which was named the Willard Asylum in memory of Dr. Willard, who died just before its final passage. This bill was drawn by Dr. Willard and Dr. Cook at Canandaigua, and Dr. Chapin was often consulted as to its phraseology and scope.

The title of the bill was "An Act to Authorize the Establishment of a State Asylum for the Chronic Insane and for the Better Care of the Insane Poor." Sections of the law stating its purpose to remove the chronic insane from the almshouses to the new asylum and making it mandatory to transfer and in future commit all acute cases to the asylum at Utica were mainly Dr. Chapin's own composition.

Commissioners were provided for in the act to locate and build the new asylum, and for this purpose Governor Fenton appointed Dr. John P. Gray, Dr. John B. Chapin, and Dr. J. T. Williams.

The commission selected the state agricultural college property in the town of Ovid, Seneca Co., N. Y., in December, 1865.

In the preparation of plans Dr. Chapin found much advantage from the care which he had taken "to acquire knowledge of all the details of institution work," and he had made a study of the subject before the Willard Asylum was proposed. As it was anticipated that "the majority of the patients to be received would be chronic cases, quiet, orderly and physically able to engage in some occupation about the farm, who might not require more than custodial care, it was planned to construct for this class buildings arranged in detached groups, located convenient to the garden and farm barns, where the patients would be near the work in which they might be engaged."

This was a radical departure from existing methods and met with the usual criticism which attends departures from prevailing methods. The plans also provided for an administration building with a main hospital group attached.

For these plans Dr. Chapin was wholly responsible, and after their adoption and approval by the governor, Dr. Gray resigned from the commission and Dr. Congdon was appointed in his place. From that time Dr. Chapin became, because of the fact that he was the only member of the commission familiar with hospital construction and management, virtually the moving force of the commission.

Under his direction the buildings were located and completed, and for the first time in this country an institution was established with a thoroughly elastic plan, with a segregation rather than a congregation of buildings, and with the distinct purpose in view of facilitating the occupation of patients upon the farm, and in other ways to aid in their own support.

Some criticism of the Willard idea has been indulged in within the last quarter of a century, but by men whose range of vision and whose experience were limited, who had no direct knowledge of the situation which confronted its sponsors, and who were perhaps conveniently blind to the fact that it was in fact the real beginning of State Care in New York. The principle of State Care was engrafted in the Willard Act. It was intended to take and thereafter keep from county almshouses the insane poor. That the legislature of the state from time to time granted excep-

tions to its provisions to various counties of the state, that the State Board of Charities did not actively enforce its provisions, was no fault of the law. The principle was there, the seed had been planted, and to Dr. Chapin belongs the credit. As he has himself written, "If any one can announce a good principle, can evolve from his mentalization some new idea calculated to improve or to contribute a mite even to the welfare of his fellow beings, there need be no concern but that it will find lodgment and not be lost." And so he paid no attention to criticism then or since, content if he had contributed his "mite."

In 1869 the buildings were so far advanced that the legislature abolished the building commission and transferred its powers and the administration of the affairs of the institution to a Board of Trustees, provided for in the original act.

On its organization this board elected Dr. Chapin medical superintendent of the new asylum. He did not desire the position and held the letter of appointment under consideration for three months before finally sending a conditional acceptance. It was represented to him that the institution should be opened by one wholly in sympathy with its purpose, the removal of the insane from the almshouses and the reception of those discharged unimproved from Utica.

The appointment was accepted upon the condition that the service was to continue during the period of organization only and not longer than three years, but subsequent events caused a reconsideration of this decision and Dr. Chapin remained at Willard until called to succeed Dr. Kirkbride at the Department for the Insane of the Pennsylvania Hospital in West Philadelphia in 1884.

The institution was prepared for the reception of patients under Dr. Chapin's direction, after his assuming the duties of medical superintendent, and on October 13, 1869, three patients, one woman and two men, were admitted. From that time dates the medical work of the institution.

Of Dr. Chapin's work, in the conduct of the hospital, it is unnecessary here to speak in detail. The record has been made in the annual reports which Dr. Chapin wrote, in the annals of the state which he so well served, and in the history of his profession.

The establishment of Willard, and particularly the principles laid down in its organic law, mark an epoch in the history of psychiatry in this country. Dr. Chapin was responsible, we have seen, for the prohibition of further almshouse care written into the act, and the whole Willard idea formed a foundation upon which might easily have been built, much earlier than was done, a State Care system, had there not been that unwise economy practised by successive legislatures, which the recently formed Hospital Development Commission, in its first report to the New York Legislature, so justly and emphatically condemned.

In Dr. Chapin's own language, "It can be asserted, without fear of question or contradiction, that the passage of the Willard law and its subsequent administration were the initial steps that eventually destroyed forever the poorhouse system for the care of the insane, and rendered possible the present comprehensive system of State Care in New York that has taken its place."

From the small beginning in 1869 a large hospital rapidly developed. We have used the term hospital with a purpose, for we wish to accentuate the fact that Dr. Chapin had from the first and on all occasions made a point of emphasizing the proposition that in the care of the so-called "chronic" insane at Willard there was to be no lowering of the standard which had been established at the then only state asylum in New York, at Utica, a standard which for a long time had been one to be modelled upon and emulated by other institutions in other states.

To again quote from Dr. Chapin, "Whoever may perchance stand upon the divide between the Lakes Cayuga and Seneca in that beautiful region of New York, and descend the gentle slopes that lead to the shores of Lake Seneca, will today see a magnificent estate of more than 1000 acres, upon which has been erected a well-equipped hospital and colony, providing for more than 2200 insane persons."

Somewhere upon a commanding site on that great estate should be erected a shaft to the memory of the man who had the vision and who had the force and perseverance to make that vision a reality. And upon that shaft should be inscribed Sir Christopher Wren's epitaph in St. Paul's Cathedral: "*Si monumentum requiris, circumspice.*" In the words of Hazlitt, "Those only deserve a monument who do not need one; that is, who have

raised themselves a monument in the minds and memories of men"; and this is singularly true of Dr. Chapin.

Shortly after the death of Dr. Kirkbride, for more than 40 years the physician-in-chief of the Department for the Insane of the Pennsylvania Hospital, Philadelphia, Dr. Chapin was asked to accept the position thus made vacant. The invitation was twice declined, the roots had struck deep at Willard—there was a disinclination to abandon a work to which for many and obvious reasons he was deeply attached—but finally he became convinced that it was his duty to accept, and in September, 1884, he entered upon a service in Philadelphia which continued for 27 years.

Dr. Chapin had in 1884 reached the age of 55. He was still active, still looked forward, and though lacking some of the elasticity of his earlier years was not lacking in enthusiasm or initiative. He saw opportunities in his new field and was not slow in seizing upon them.

But two members of the medical staff remained to serve under him, and he found it necessary to find others to take the vacant places; the methods of administration in vogue had to be learned, and, as necessity arose, modified. Careful clinical study was urged upon his assistant staff, and as far as possible pathological and clinical laboratory work encouraged; and, in short, without making any revolutionary changes new ideas and new methods were brought into prominence.

Shortly after going to Philadelphia a fire occurred in the insane department of Blockley, the city almshouse and hospital. Several insane patients lost their lives and much property damage was incurred. Blockley Asylum had long been condemned as a place of detention for the insane. The Association of Medical Superintendents of American Institutions for the Insane had repeatedly put its stamp of disapproval upon it, but conditions which should long before have been changed were permitted to continue.

After the fire Dr. Chapin and the writer, but recently called to Philadelphia as his assistant, were asked to confer with the Board of Guardians of the Poor as to the best course to follow. At that conference Dr. Chapin outlined a plan which if followed would have given Philadelphia the honor of establishing the first Psychiatric Clinic in the United States. He pointed out to the board the real situation; showing them that Blockley was badly over-

crowded, that there were no adequate means of exercise in the open air, no provision for occupation, no proper nursing, and not sufficient medical care and supervision. He called attention to the very large annual admission rate, small recovery rate and a large death rate. He then dwelt upon the need of training in psychiatry for young men, which then in this country in medical schools was wholly lacking, and the excellent clinical opportunities at Blockley for the medical schools of the city. He said:

Establish here a small hospital of from 100 to 200 beds, to which all cases coming under city care shall be sent at once. Concentrate here the medical work, to be done by a large resident staff under a competent chief. Establish laboratories and all the requisites of a good hospital, and use the material for clinical instruction. A certain proportion of the cases admitted will need but a few weeks' care here; many others, longer care, and many permanent care. Establish therefore in the country a colony farm with its hospital and medical and nursing staff, and its groups for permanent cases who should be employed on the farm and in shops, and contribute to their own support.

We have given here but a hasty outline of a lengthy conference, but it can be seen what an excellent scheme was laid before the board—only, alas, to be rejected as too expensive! The burned wards were rebuilt, and the old routine went on, to the everlasting disgrace of the city of "Brotherly Love."

Dr. Chapin soon fell into his natural place in the medical, philanthropic and social life of Philadelphia, and was an effective force in the life of the city and the state.

He was elected president of the Association at the meeting held at Old Point Comfort, Va., in 1888, and delivered the presidential address the following year at the meeting at Newport, R. I.

Among other things in this notable deliverance he touches upon a movement made in 1887 to revise the "Propositions." He said:

Any propositions we might adopt are but announcements of opinions held to-day, which 20 years hence may come to be regarded by those who follow us as inapplicable platitudes. Is it proper to restrict and define the freedom of thought, inquiry and expression of opinion that we today enjoy? Is it just to those who may follow us to attempt to set a limit to the tendencies of the future? . . . . Ought it ever to occur again that the presentation and consideration of important subjects at our meetings can be antagonized by no better argument than by so-called principles and propositions adopted a score of years previously and under conditions perhaps entirely changed?

In this last paragraph one can catch a reflex of Dr. Chapin's experiences in the discussion of the Willard plan at the meetings of the Association.

In the address referred to he also called attention to the inadequate salaries paid to medical officers of hospitals for the insane in many instances. He was always of the opinion that some provision should be made for a retirement allowance after a certain number of years' service, and an advocate of a secure tenure of office for medical superintendents, without the fear of political interference therewith, which is so often the case.

Dr. Chapin received the honorary degree of LL. D. from Jefferson College, Pennsylvania, and from his alma mater, Williams College. He was a fellow of the College of Physicians of Philadelphia, and an honorary member of the Medico-Psychological Association of Great Britain and Ireland and the Société de Médecine Mentale de Belgique.

In 1898 he published a "Compendium of Insanity" for the use of students and general practitioners, which was well received, and served a most useful purpose.

On the first of December, 1904, he was given a complimentary dinner at the Bellevue-Stratford Hotel in Philadelphia, which was very largely attended, and which marked the completion of fifty years' work in hospitals for the insane. On this occasion he was presented a life-size portrait of himself, copies of which were afterward placed in the hospital in West Philadelphia and at the Willard State Hospital. Subscriptions for the dinner and portrait came from all parts of the country as well as from abroad, and the after-dinner speeches, the letters and telegrams which came from many unable to be present, united in voicing the affectionate regard which the many friends of the honored guest felt for him, and the high esteem they had for his attainments in his chosen field of work.

It is given to few men to round out a half-century of active constructive work, and to retain the mental and physical vigor which was shown by Dr. Chapin on that occasion.

He had exceeded the Psalmist's limit of three score and ten, and on more than one occasion then and afterwards brought before the managers of the hospital the question of laying down his office, but was assured that it was the desire of the board that he continue

to preside over the conduct of the hospital as long as he felt in condition to carry on the work.

For seven years longer he remained at the hospital in West Philadelphia, resigning, and moving to a home which he had prepared in Canandaigua, in the summer of 1911. His last attendance at a meeting of the Association was in 1913 at Niagara Falls. He then showed little of the physical weakness of age and no perceptible diminution of his mental vigor. He carried on a correspondence with his more intimate professional friends until within a few months of his decease. It was a common thing to find at the close of a letter a postscript which read, "Does my handwriting show any of the effects of age?" He read the *AMERICAN JOURNAL OF INSANITY*, and commented from time to time on its contents. The account of the proceedings of the meeting in New York published in the number for October, 1917, he followed with interest.

In the early summer of 1916 he met the greatest grief of his life, in the death of his wife, after more than fifty-eight years of the most intimate and loving association.

To those who have had the honor and pleasure of an intimate knowledge of Dr. Chapin's home life some appreciation will come of the great blow which thus descended upon him. Mrs. Chapin had met with an accident several months prior to her death which practically confined her to her room, and the doctor's assiduous attention to her filled her days with peace and comfort. After her departure he seemed more or less dazed. He could not adjust himself to the changed conditions—he had lost not only his occupation in looking after her every wish, but he had lost his bearings in a measure.

He passed a portion of the summer of 1917 with his children and grandchildren at a summer home near Albany on the Hudson, and in many ways appeared like his old self, but he missed the voice that was gone, and the touch of the vanished hand.

His home life after his wife's decease was made as cheerful as possible by the continued presence in turn of one of his daughters, of whom three, all married, and one son, survive him. He occupied himself with writing and with his books, and in seeing his friends.



He went about the streets of the beautiful old town when the weather permitted. A day or two before his death he went down town with his daughter, and shortly after returning home complained of feeling ill. When a physician was sent for he said it was unnecessary, as he knew what was the matter—it was the breaking down at the end, and so it proved to be. He retained his old jocular manner almost to the close. His medical advisor called in a consultant and together they gave their patient a thorough physical examination. As they went from the sick room to confer he remarked, "They'll go down stairs and give my disorder a name, but that will not change the result." The end came rapidly, with fortunately little suffering, and on the afternoon of Thursday, January 17, 1918, "in the comfort of a reasonable religious and holy hope," he fell asleep.

Dr. Chapin's great force arose from his self-control, and his careful preparation for the work before him, which led him to study every problem presented with a feeling as he expressed it that the knowledge obtained would become available "somewhere, at some time." He was a man of most straightforward character, with no suspicion of indirectness in his methods. Of deep religious convictions, he carried his religion into his daily life and made it a religion of service to God and his fellowman. In this he exemplified Whittier's dictum, "He who blesses most is blest."

As a great administrator, as a far-seeing philanthropist who accomplished more for his fellowmen than can now be estimated, as a conscientious and well-trained physician, he has set his mark upon the history of his country and his profession.

"Servant of God, well done; well hast thou fought  
The better fight."

EDWARD N. BRUSH.

## DR. CHARLES H. NORTH.

Some men subscribe to the Hippocratic oath, others live it. Dr. Charles H. North, Superintendent of the Dannemora State Hospital for the criminal insane, was of the latter, and he stood at a professional altitude which medical students might well mark as their goal. Dr. North died Wednesday, December 12, 1917, from stab wounds inflicted by an inmate of the institution over which he had supervision and which he had made one of the foremost in the treatment of insane criminals in this country. The Dannemora State Hospital was recognized as such, and its prestige was acquired by high ideals and unswerving purpose.

The success of Dr. North was due to his devotion. From the day he entered the service of the State of New York as medical interne at Matteawan State Hospital he concentrated every thought and energy to the task which was before him. Determination which was necessary for preliminary education gave him the poise to remain practical, and his worth was soon considered by seniors in the profession. It was predicted that he would be what he was, and within six years from the day he registered at Matteawan he was made superintendent at Dannemora. This was on December 17, 1904, a record for those entering the service.

If modesty is one of the sustaining elements in upholding the standards of any profession, no man ever contributed more to the ethics of his calling than did Dr. North. His presence in the councils of the societies with which he was associated, even without utterance, was vigorous opposition to the spectacular, a leaning towards which there had been for the care of the insane criminal as well as the sane. His fight was against methods urged by emotion and which could not be supported by intelligent diagnosis. His stalwart refusal to recede from that which he knew by years of experience was right earned for him the intrinsic respect of superior officers, those in subordinate places attached to the hospital, and all others who had opportunity to know him well enough to estimate his professional mentality and his personal integrity. Dr. North once said, "If we are to go forward, intelligence and integrity must accompany us every inch of the way."

While attending a meeting of medical superintendents recently, he casually stated that the moment any physician or surgeon ceased to be a student he ceased to be of any further value to his profession. He exemplified this in the treatment of the state's charges at Dannemora and in the management of the fiscal affairs of the hospital. He had but one ambition, and that was to enlarge the efficiency of every department of the institution. During his administration its capacity was substantially doubled, additional structures having been erected with scarcely more than inmate help under instruction of the officered staff. Large wings were built on the northwest and southwest extremities of the hospital proper; also a mess hall, infirmary and shop buildings, together with a large storehouse and cold storage plant.

That Dr. North was a student is further verified by papers which he had written, which were widely printed and which were accepted as authoritative by members of his profession. During a period of unrest when there appeared to be a danger of the emotional submerging the intellectual, Dr. North held firmly to his conviction that in the end safe and sane professional procedure would triumph. He was confident as to the outcome, and in his contributions to the medical journals and other periodicals he never omitted to register his views, and with full knowledge that criticism would ensue. That attack might come, however, did not deter him from that which he knew was his bounden duty to his profession.

Among his offerings was a paper: "The Mind of the Criminal," which he read before the New York State Federation of Women's Clubs at Rochester in November, 1916. This article was quoted extensively, the opposition to it emanating largely from a laity working along lines of uplift. The profession, nevertheless, received it with approval. Other papers were: "A Proposed Change in the Criminal Law," "Insanity Among Adolescent Criminals," and "The Attitude of the Commonwealth Towards Public Institutions." Subsequent to the publication of his opinions relative to changes needed in the criminal law, amendments were framed and legal processes as bearing on commitments and releases of insane criminals were enacted into law, bringing order out of confusion. For these analyses he was commended by those

who saw the errors but who failed to point the road to a solution.

Dr. North was appointed medical interne at Matteawan State Hospital on July 16, 1898. Two years later he was made First Assistant Superintendent to Dr. Robert B. Lamb, who was then Superintendent at Dannemora. With the transfer of Dr. Lamb to Matteawan, Dr. North was made Superintendent at Dannemora, his appointment having the date of December 17, 1904. When Dr. North assumed the superintendency the building had advanced little beyond a formulative stage, so that which it is to-day bespeaks volumes for the studious attention which he gave to details of construction, the hospital being abreast of the times in institutional equipment.

The out-of-doors appealed to Dr. North strongly, his vacation days being spent in the main with rod and gun. Life in the open had that charm for him which explains, undoubtedly, his position in the front rank of naturalists in the state. He was also a lover of music, and as first violin of the institution orchestra he lifted this ensemble far above amateur limitations.

In his death the State Department of Prisons, quoting Superintendent James M. Carter, loses a man whose place will be difficult to fill but whose faithfulness and sterling qualities actuated him to build an organization which will be a bulwark of assistance to the bureau for all time.

He was a member of the American Medico-Psychological Association, Medical Society of the State of New York, National Prison Association, Northern New York Medical Society, Omega Upsilon Phi (medical fraternity), American Forestry Association and American Civic Association.

Dr. North was born at Palmyra, N. Y., and was the son of Henry M. North, M. D., and Sarah Jane (Grover) North. He was educated in the Palmyra High School and was graduated from the University of Buffalo in 1898. On November 15, 1905, he was married to Luella Barber Robinson of Clyde, N. Y., who, with three children, survives him. The interment was at Palmyra.

## DR. GEORGE VILLENEUVE.

Dr. George Villeneuve, the late Medical Superintendent of the St. Jean de Dieu Hospital for the Insane, Gamelin, Que., and likewise late Professor of Mental Diseases at Laval University, Montreal, died on the 21st of January last, at Quebec City.

Born at Montreal on the 9th of November, 1862, he was the son of James Edward Villeneuve, in his lifetime Inspector of Customs, and of Julie Fortin, sister of the late Senator Pierre Fortin. These two families were among the most distinguished of the early French-Canadian settlers in the Province of Quebec. His early education he received at the Montreal College. His classical course at that institution having terminated, he entered the Civil Service at Quebec City. In 1885, as captain of the 65th Battalion, he took part in the Northwest Rebellion, and on the termination of the Insurrection he was awarded a medal for military service. In 1889 he graduated in medicine at Laval University; upon obtaining his degree at Laval, he went to Paris, where he studied under the most eminent professors of legal medicine and psychiatry of the time, amongst others, Brouardel, Magnan Dejerine, Babinski, Andre Thomas and Garnier. Upon returning to Canada, he was named joint physician with the late Doctor Johnson, and subsequently with Colonel McTaggart, as medical advisor to the Coroner's Court, at Montreal. In 1894 he was appointed by the Quebec Government Medical Superintendent of the St. Jean de Dieu Hospital for the Insane, a position which he actively occupied until May, 1917, when, owing to increasing ill health, he was obliged to discontinue his labors which, unfortunately, he was never able to resume.

Intimately identified with him for a period of nearly a quarter of a century, I have, in every way, been able to appreciate the great changes which he has brought about for the improvement and welfare of the unfortunate afflicted ones committed to this institution. In addition to his scientific attainments, he was a man gifted with a marked administrative ability, and succeeded, despite the rather meager pecuniary resources at the disposal of this hospital, in raising the standard of the institution to a very

high plane. A close student of all the departments of medicine, he continually sought to improve himself in that branch of it which was his life work, and a valuable library in the hospital remains as a lasting tribute to his efforts.

As a writer, he has left a number of brochures on the subject of insanity and crime, which bear ample testimony to the high order of his powers as a thinker and an observer. Familiar from his youth with both the French and English languages, he, later in life, mastered the Italian tongue, and was thus able to follow, on all questions of psychiatry and neurology, the ideas expressed by the master minds of these different nationalities.

Ever kind to those committed to his care, he was a wise administrator, an able physician, a faithful friend, and, in the death of Doctor Villeneuve, in the prime of life, at the height of his usefulness, sincerest sorrow is felt by all those who have been associated with him.

## DR. THOMAS COKE BIDDLE.

Dr. Thomas Coke Biddle was born near New Maysville, Indiana, September 14, 1857. He was reared on the farm—that environment which has produced so many of our best and strongest men. It was there that he early acquired the traits of industry, integrity and self reliance, which were so characteristic of him throughout his life. He attended the public schools and was for a time a student at Asbury College. His medical education was obtained at Rush Medical College where he graduated in the class of 1881. Two years later he married Miss Alva Egbert of Lebanon, Ohio, who survives him.

Believing that the West offered advantages over his native state, Dr. Biddle, directly after his graduation, came to Kansas and began the practice of medicine in the town of Reading. A few years later he moved to Emporia, where he lived until he entered the state service as Superintendent of the Hospital for the Insane at Osawatomie in 1895. He resigned from this position to enter the medical corps of the U. S. volunteer army in 1898. Dr. Biddle was in active service during the Spanish-American war, first with the 21st Kansas Regiment at Chicomauca and later with the 4th Ohio Regiment in Porto Rico.

Shortly after being mustered out of the army he was appointed Superintendent of the Topeka State Hospital and assumed charge April 1, 1899. He remained continuously in this position until the time of his death, which occurred February 16, 1918. During this period of nearly twenty years the institution was greatly enlarged and many substantial improvements were made. Dr. Biddle early recognized the advantages of the cottage plan of institution construction and designed and supervised the erection of a number of modern cottages which add much to the attractiveness and practical worth of the Topeka Hospital. The crowning achievement of his long years of service devoted to the care of the insane was the building and equipping of a reception hospital for the special treatment of acute and remediable cases. The Board of Administration has recently directed that this building, which is a model of its kind, be designated as the T. C. Biddle Hospital in recognition of his services

to the institution and the state and as a fitting tribute to his memory.

Dr. Biddle was gifted to an unusual degree with that balance of character so necessary in a successful state hospital superintendent. He possessed in combination with professional attainments of a high order, remarkable executive ability, and sound, conservative business judgment. Personally he was modest and unassuming to a fault, and his natural reticence caused him to be misunderstood at times by some who did not know him well. To intimate acquaintances, however, and especially to those who enjoyed his friendship, he was candid, frank, and genial. He was honest with himself, just in his relations with his fellow man, and loyal to his friends. Those who knew him best loved him most.

M. L. PERRY.



## SUBJECT INDEX

---

### A

Analysis, An, of the Accuracy of Psychopathic Hospital Diagnoses. Lawson Gentry Lowrey, 349.

### B

Biddle, Dr. Thomas Coke, Memorial Notice of. M. L. Perry, 391.  
By-Laws, 91.

### C

Chapin, John B., M. D., LL. D., Memorial Notice of. Edward N. Brush, 369.  
Classifications, Recent American, of Mental Diseases. E. E. Southard, 253.  
Clinical Summary, A, of 106 Cases of Mental Disorder of Unknown Etiology Arising in the Fifth and Sixth Decades. E. T. Gibson, 223.  
Community Mental Health Movement, The, and its Probable Dependence for Success on a Higher State Hospital Standard for Ward Employees. Sidney D. Wilgus, 337.  
Connecticut Hospital for the Insane, Pellagra at the. William C. Sandy, 289.  
Conservation in a Provincial Hospital, Food, Service and. J. C. Mitchell, 309.  
Constitution, 86.  
Content, The, of the Schizophrenic Characteristics Occurring in Affective Disorders. Phyllis Greenacre, 161.  
Critical Review, A, of the Pathogenesis of Dementia Praecox, with a Discussion of the Relation of Psychoanalytic Principles. Michael Osnato, 167.

### D

Decades, A Clinical Summary of 106 Cases of Mental Disorder of Unknown Etiology Arising in the Fifth and Sixth. E. T. Gibson, 223.  
Dementia Praecox, A Critical Review of the Pathogenesis of, with a Discussion of the Relation of Psychoanalytic Principles. Michael Osnato, 167.  
Depressions, The Psychologic Treatment of Retarded. L. Pierce Clark, 157.  
Diagnoses, An Analysis of the Accuracy of Psychopathic Hospital. Lawson Gentry Lowrey, 349.

### F

Food, Service and Conservation in a Provincial Hospital. J. C. Mitchell, 309.

## G

Geographical Distribution of Members and Institutions, 53.

## H

Honorary Members, 48.

## I

Illinois, The Organization of the State Hospital Service in. H. Douglas Singer, 207.

Interpretation of the Functional Nervous Diseases at the Physicochemical Level. D. W. Roberts, 189.

## K

Kentucky, The Mental Deficiency Survey of, 1917. Thomas H. Haines, 195.

## L

Life Members, 47.

List of Members, 9.

## M

Meeting Places of the Association, 52.

Mental Defects, Psychoses in. Alfred Gordon, 317.

Mental Deficiency Survey, The, of Kentucky, 1917. Thomas H. Haines, 195.

Military Camps, The Work of Psychiatrists in. E. Stanley Abbot, 299.

## N

Necrology, 49.

Nervous Diseases, Interpretation of the Functional, at the Physicochemical Level. D. W. Roberts, 189.

Neurosyphilis, Treatment in. Benjamin F. Williams, 285.

North, Dr. Charles H., Memorial Notice of, 386.

Note, 92.

Nursing Problem, The, as Related to Psychopathology. Richard Dewey, 329.

## O

Organization, The, of the State Hospital Service of Illinois. H. Douglas Singer, 207.

## P

Pellagra at the Connecticut Hospital for the Insane. William C. Sandy, 289.

Personality, The Study of the, in Psychiatric Cases. George S. Amsden, 273.

Presidential Address. James V. Anglin, 139.

Presidents of the Association, 50.

Proceedings of the Seventy-fourth Annual Meeting, 93.

- Provincial Hospital, Food, Service and Conservation in a. J. C. Mitchell, 309.  
 Psychoanalytic Principles, A Critical Review of the Pathogenesis of Dementia Praecox, with a Discussion of the Relation of. Michael Osnato, 167.  
 Psychologic Treatment, The, of Retarded Depressions. L. Pierce Clark, 157.  
 Psychopathology, The Nursing Problem as Related to. Richard Dewey, 329.  
 Psychoses in Mental Defects. Alfred Gordon, 317.

R

- Recent American Classifications of Mental Diseases. E. E. Southard, 253.  
 Rehabilitation, The, in the Community of Patients Paroled from Institutions for the Insane. Samuel N. Clark, 217.

S

- Schizophrenic Characteristics, The Content of the, Occurring in Affective Disorders. Phyllis Greenacre, 161.  
 Secretaries of the Association, 51.  
 Service and Conservation in a Provincial Hospital, Food. J. C. Mitchell, 309.  
 State Hospital Service in Illinois, The Organization of the. H. Douglas Singer, 207.  
 State Hospital Standard for Ward Employees, The Community Mental Health Movement and its Probable Dependence for Success on a Higher. Sidney D. Wilgus, 337.  
 Study, The, of the Personality in Psychiatric Cases. George S. Amsden, 273.

T

- Treatment in Neurosyphilis. Benjamin F. Williams, 285.  
 Treatment, The Psychologic, of Retarded Depressions. L. Pierce Clark, 157.

V

- Villeneuve, Dr. George, Memorial Notice of, 389.

W

- Work, The, of Psychiatrists in Military Camps. E. Stanley Abbot, 299.

## AUTHORS' INDEX

---

### A

- Abbot, E. Stanley.. The Work of Psychiatrists in Military Camps, 299.  
Amsden, George S. The Study of the Personality in Psychiatric Cases,  
273.  
Anglin, James V. Presidential Address, 139.

### B

- Brush, Edward N. Memorial Notice of John B. Chapin, M.D., LL.D.,  
369.

### C

- Clark, L. Pierce. The Psychologic Treatment of Retarded Depressions,  
157.  
Clark, Samuel N. The Rehabilitation in the Community of Patients  
Paroled from Institutions for the Insane, 217.

### D

- Dewey, Richard. The Nursing Problem as Related to Psychopathology,  
329.

### G

- Gibson, E. T. A Clinical Summary of 106 Cases of Mental Disorder of  
Unknown Etiology Arising in the Fifth and Sixth Decades, 223.  
Gordon, Alfred. Psychoses in Mental Defects, 317.  
Greenacre, Phyllis. The Content of the Schizophrenic Characteristics  
Occurring in Affective Disorders, 161.

### H

- Haines, Thomas H. The Mental Deficiency Survey of Kentucky, 1917, 195.

### L

- Lowrey, Lawson Gentry. An Analysis of the Accuracy of Psychopathic  
Hospital Diagnoses, 349.

### M

- Mitchell, J. C. Food, Service and Conservation in a Provincial Hospital,  
309.

## O

Osnato, Michael. A Critical Review of the Pathogenesis of Dementia Praecox, With a Discussion of the Relation of Psychoanalytic Principles, 167.

## P

Perry, M. L. Memorial Notice of Dr. Thomas Coke Biddle, 391.

## R

Roberts, D. W. Interpretation of the Functional Nervous Diseases at the Physicochemical Level, 189.

## S

Sandy, William C. Pellagra at the Connecticut State Hospital for the Insane, 289.

Singer, H. Douglas. The Organization of the State Hospital Service in Illinois, 207.

Southard, E. E. Recent American Classifications of Mental Diseases, 253.

## W

Wilgus, Sidney D. The Community Mental Health Movement and its Probable Dependence for Success on a Higher State Hospital Standard for Ward Employees, 337.

Williams, Benjamin F. Treatment in Neurosyphilis, 285.











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